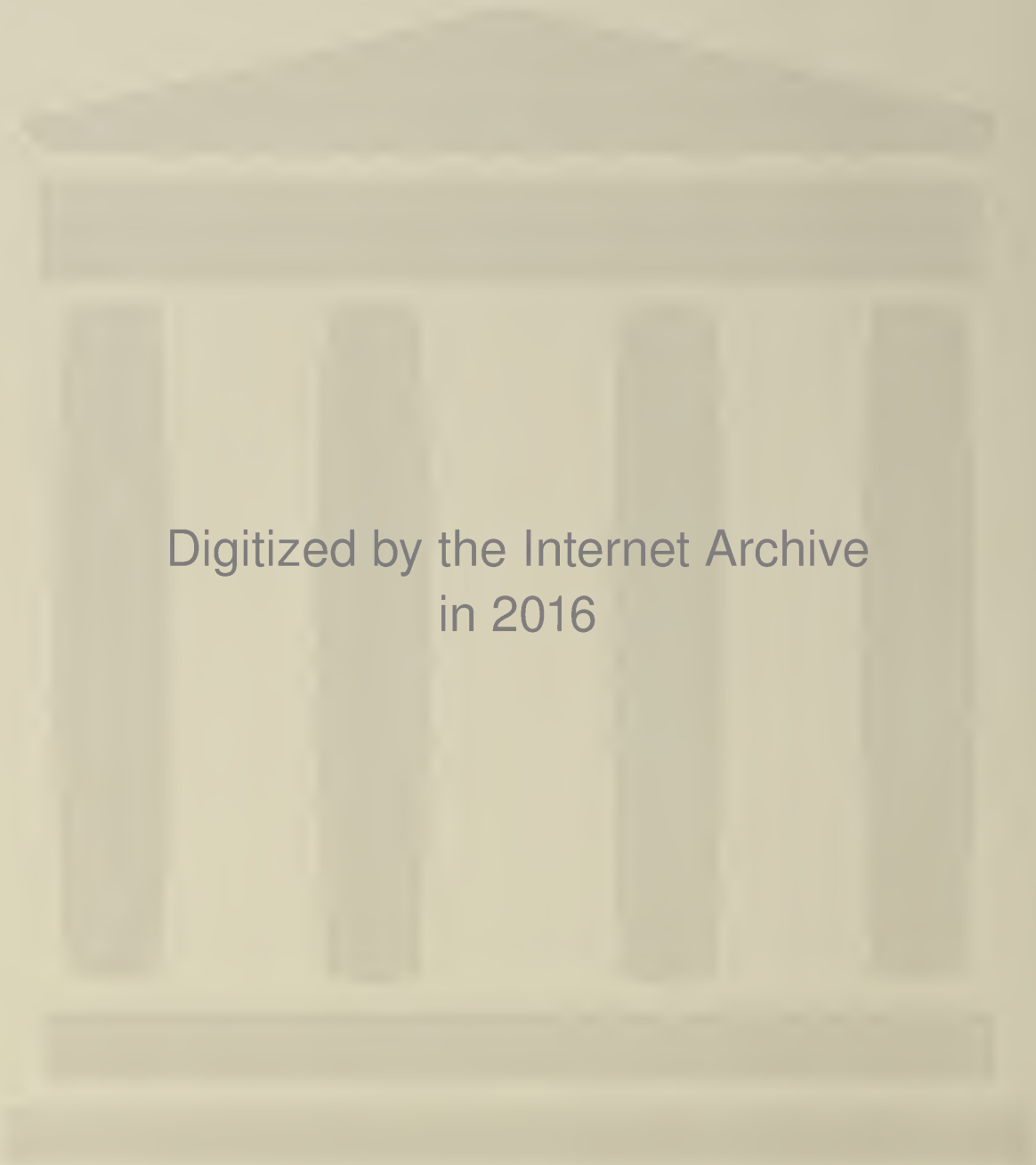
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Volume 86 Number 1 June, 1989



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Arkansas Medical Society President, James R. Weber, M.D., and his wife, Cynthia Weintraub Weber

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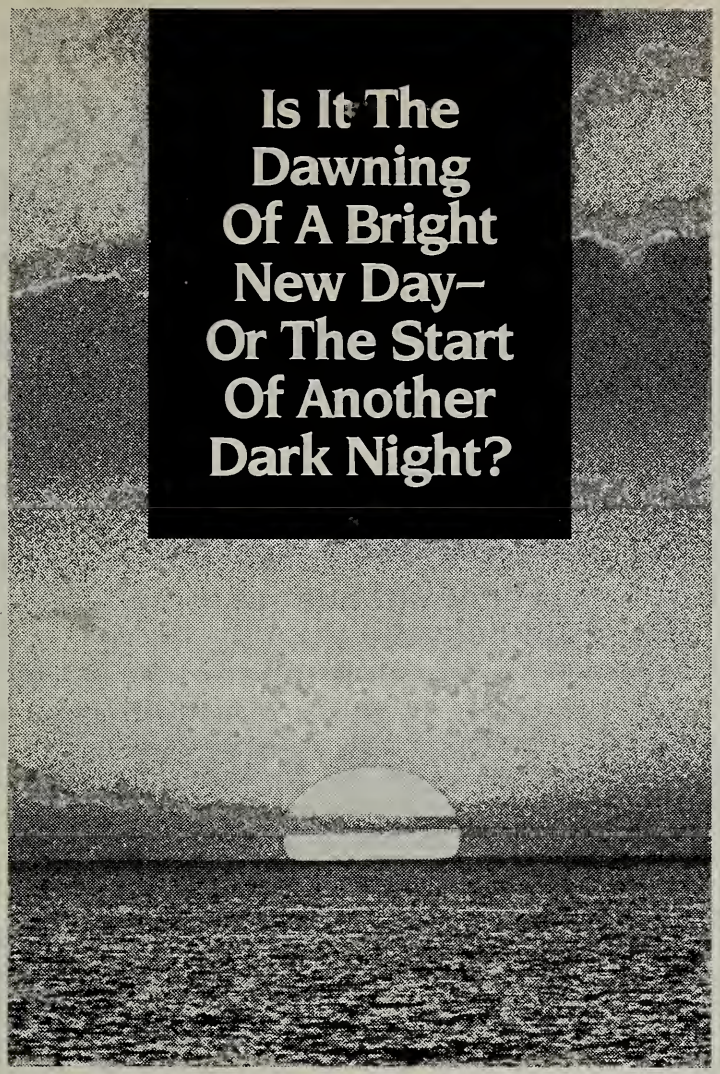
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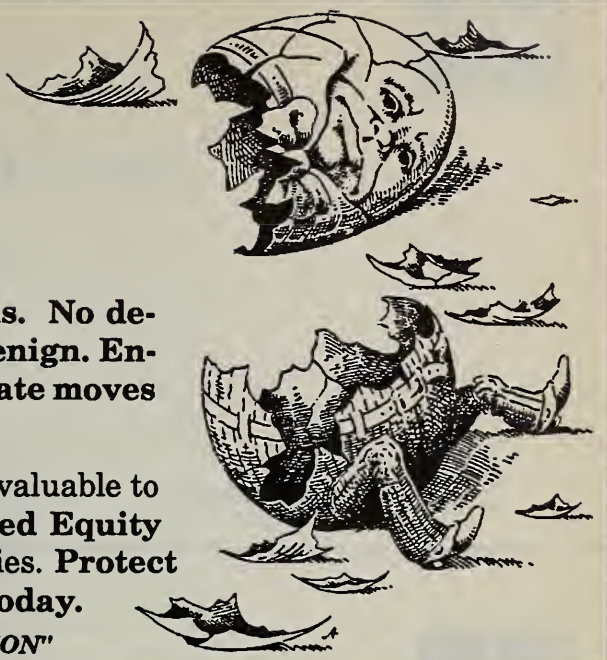
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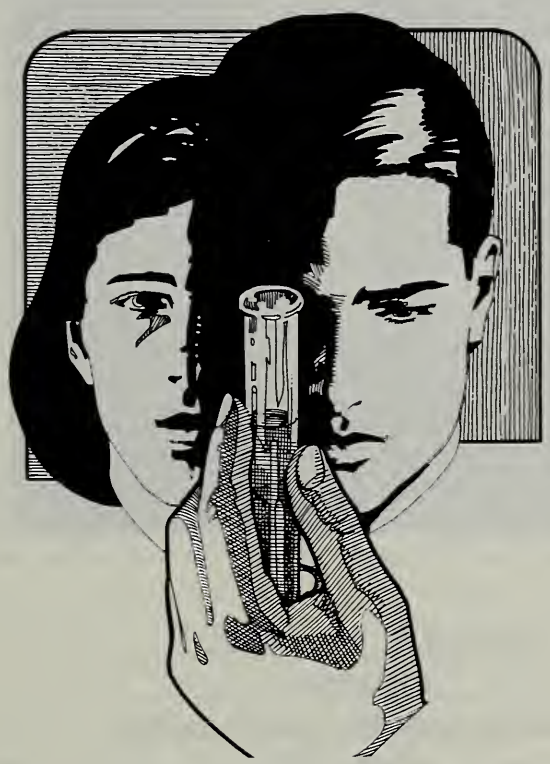
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Proceedings
113th Annual Session
of the
Arkansas Medical Society
April 27 - 29, 1989



James R. Weber, M.D.
President
Arkansas Medical Society
1989-1990
Jacksonville, Arkansas

Inaugural Address

Dr. Hestir, fellow physicians, members of the Auxiliary, family and friends, it is a great honor and privilege to be installed as President of this organization. To have been chosen by you, my colleagues, is a recognition that gives me the greatest personal satisfaction. I accept this position with humility and view it as a great challenge as we focus on the future of medicine.

At any time in the history of medicine, there have always been great changes occurring and today is no different. Our challenge for the future, as I see it, is to exert influence to make sure that these changes benefit the patients we serve and improve the environment of medical practice.

In this complex task, the practice of medicine, we know that our number one partner is our family. I thank you for providing this opportunity for me to have such a wonderful family reunion here today. I will take a moment to introduce my family to you. My wife, Cynthia, and my children, Jodi, with her husband, John Klein, and their son, Tyler; Dana, Amy, Todd, and Allen. My sister, Jan Lindgren and her husband, Don, have joined us tonight with my nephew, Steve. Also, with us are my brother-in-law, Alvin Weintraub and his wife, Gail, and my uncle, Dr. Alvin Strause and his wife, Lesley.

Not here this evening in person, but certainly with me in spirit, are four people who have had a great influence on my life: my parents, Bertha and Ray Weber, and my aunt and uncle, Inez and Homer McConnell. Both couples are well up in their eighties and were unable to make the trip from Nebraska.

The Auxiliary is family. I will take this opportunity to thank Sarah Jouett for her outstanding leadership as President of the

Auxiliary this past year and congratulate Nikki Lawson for being installed as president for the coming year. The work and influence of the Auxiliary is so important to our success.

Every time I go to #10 Corporate Hill, I look at the Society's magnificent headquarters building as a symbol of the quality of the people involved. It is my pleasure as your new president to tell Ken LaMastus, Lynn Zeno, David Wroten and all of the headquarters staff that we think they are doing a great job and we really do appreciate them. A special thanks to Peggy Cryer and her staff for the outstanding organization of this meeting.

Our future is our promise, and it will come one day at a time. What we do each day does make the difference. At this time, I want to recognize a special group of people who make each day of my life and practice a special day. It is a privilege to introduce to you my office staff: Charlotte Chambers, our receptionist, and her husband, Henry; Ruth Merrill, R.N., a very special lady in our office; Jana O'Dell, insurance secretary and medical transcriptionist, and her husband, Steve; Cindy Jeffers, account manager and her husband, Bobby; Laura Patton, R.N., who is my right hand and her husband, Ralph, who is manager of the Network Reference Lab that I share with 17 other physicians; Angela Brown, X-ray technician, and her husband, R.C.; Julie Brooks, dietician, and her husband, Ted; and Carl Runyan, and his wife, Myra. I want to thank you all for coming.

I am also honored to have some very special friends and guests tonight. Please welcome Congressman Tommy Robinson, and his wife, Carolyn; Col. McLyle Zumwalt and his wife, Joan; Representative Doug Wood, and his wife, Crystal and Representative Mike Wilson, and his friend, Sammye Frazier

Soon, the Arkansas Medical Society will be holding a press conference to announce establishment of the Arkansas Physicians Care program. I have said before that to be seriously ill and totally broke - financially devastated - without access to health care, might be comparable to being held hostage by terrorists in other parts of the world. This should not happen in America. At this time, numerous physicians of our Society, in all specialities and from all areas of the state, have volunteered to treat these patients free of charge and give them access to the health care system. This foundation at the Society's headquarters will man an 800 number to make appointments and direct these patients to those of you who have volunteered to participate. I think this is a great project. At this time, I want to extend a special thanks to the Indigent Care Committee and to three of your most recent presidents, who, along with the Council and staff have established this Foundation: Drs. Asa Crow, Ray Jouett, and John Hestir. It will be my great pleasure to help you carry this project forward.

In our state today it is true that approximately one-fourth of the people do not have health insurance or even Medicaid. Twenty-three percent of our citizens' income is below the federal poverty level and Arkansas Medicaid covers only about one third of this population. The Foundation for Access to Care is our effort to help these families with destitute financial circumstances gain access to the health care system through a caring physician.

I challenge every red-blooded physician in the state to join this effort. I know that everyone here has volunteered, but when you go back home, talk to all of your colleagues and make this a community effort.

Yes, today we continue to face a liability crisis that seems to be escalating for the future, at least in the sense of higher awards and higher premiums. This crisis in some areas of the country and of our state seriously threatens the availability of medical care, especially obstetrics, and even the ability of physicians to continue in practice. We take note that tort reform laws are not working as well as we had hoped and during this session, we have learned some reasons for this from Mr. Peter Huber, author of the outstanding book, *Liability, the Legal Revolution and its Consequences.* I hope all of you heard his address.

However, we should not forget to count our blessings. In Arkansas, premiums continue to be among the lowest in the country and we now have four excellent companies writing medical liability insurance for us. In this aspect, today may be the best of times.

I do want to take this opportunity to again thank Attorney Bill Eldridge, who we all know as one of the finest defense lawyers in America. I could not be more pleased on this occasion for us to honor such a distinguished citizen and long-time friend as the recipient of the Shuffield Award. Bill, would you and your wife please stand? We appreciate you and the great work you have done for Arkansas physicians. We thank you from the bottom of our hearts.

I applaud the great progress we have made in medical science and technology this past decade. I predict that we are, right now, on the threshold of developing some unbelievable new scientific advances in medicine. This is exciting to me; however, we must remember that this technology only becomes of benefit when it is made available and applied to our individual patients. We cannot allow such progress to become a mere scientific curiosity by deciding to ration or delay its application to the people as is commonly done in Canada, Great Britain, and some European countries. I don't think the American citizens would stand for that. Our challenge as physicians is to use these resources appropriately and to help make them available and affordable to the people.

We ought not to be so enamoured with technology, however, that we forget that high tech without high touch could be empty indeed. I like to think that high touch with high tech will be the wave of tomorrow.

The prescription for the 1990s, I predict, must have more emphasis on preventive care, early diagnosis and risk management for the major killers. It is amazing that among the most dangerous things we do in America are smoke cigarettes, drive cars without seatbelts fastened, and wait for the symptoms of heart attack, stroke or cancer before we go to get examined. No one would deny today that sexual promiscuity is dangerous.

We all know that third party payors rarely cover preventive services; however, I predict this will change. To credit the cost of preventive services toward the deductible is one way to begin to phase these strategies into the financing system



During the Inaugural Banquet, Saturday, April 29, Dr. James R. Weber, of Jacksonville, accepts the gavel and the presidency from Dr. John M. Hestir, DeWitt, Arkansas Medical Society president from 1988-1989.

without too great an impact on costs, but still with an incentive. This is an idea yet to be tried.

All of us recognize the great potential in this area to improve the quality of life and in the long run to favorably affect the cost of health care. It is our challenge to make preventive care more affordable and available to our patients as we focus on the future.

You all know how strongly I feel about our involvement in the political process. We must appreciate that the decisions and policies that will shape the future of medicine, to a great extent, will be made in the Congress and in our state legislature. Every physician and spouse in this state should be a member of organized medicine and financially support the legislative efforts. We will be working for that kind of unity. We must encourage our members to do even more.

Political power and the ability to influence change is fueled by active participation at home. This grass roots effort is where the power lies. This base, when solidified by unity and an organized effort, becomes a very strong force. This is the way that we can guarantee that the changes made in the future of medicine will benefit our patients to a maximum and will create an environment that is friendly and helpful to the doctors providing that care. This is the way we can make Arkansas and America a better place to live, a better place to be a patient and a better place to practice medicine.

It is no mystery to me why health care is the largest service industry in America. It is obvious that the quality of life in the American way is closely tied to excellence in health care. It is for these reasons and because of the aging population of which we are all a part, I predict that the amount of resources devoted to health care will increase through this century and into the next. I do not think that the American people will accept a stifling policy of rationing or one of socialism.

I still believe that the best strategy of a practicing physician today remains the personal and high quality care of his or her patients and to be the patient's advocate. This means preserving and improving the access to care in all communities; it means providing comprehensive and continuing care at the cutting edge of medical knowledge and technology; and it means care that is affordable. I believe that this will be the focus of the future of medicine. The key to the future is the action we take today. Thank you.



Dr. Holwick outside of hospital where she practices as a civilian traumatologist.



Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.; University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA Medical Center.

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.

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Proceedings
113th Annual Session
of the
Arkansas Medical Society
Hot Springs, Arkansas
April 27 - 29, 1989

First Session
House of Delegates
Thursday, April 27, 1989

Speaker of the House, Sybil Hart, called the House of Delegates to order at 5:00 p.m., on Thursday, April 27, 1989, at the 113th meeting of the Arkansas Medical Society Annual Session. She called upon Fred Henker to give the invocation.

The colors were presented by the Hot Springs High School R.O.T.C., followed by a welcome from Elijah Harris, acting mayor of Hot Springs.

Members of the Society seated as officers, councilors, and delegates were:

Officers

James Gardner, Sybil Hart, John M. Hestir, W. Ray Jouett, James M. Kolb, Jr.; Charles Rodgers, James R. Weber.

Councilors

District 1	Merrill J. Osborne
	J. Larry Lawson
District 2	Jim E. Lytle
	John E. Bell
District 3	Hoy B. Speer, Jr.
	L. J. P. Bell
District 4	Lloyd G. Langston
	Paul A. Wallick
District 5	Cal R. Sanders
District 6	F. E. Joyce
	James D. Armstrong
District 7	Ronald J. Bracken
District 8	David L. Barclay
	Paul Cornell
	William N. Jones
	Charles Logan
	Harold Purdy
District 9	Robert H. Langston
District 10	Morton Wilson

Delegates

Arkansas	NOT REPRESENTED
Ashley	Don L. Toon
Baxter	Robert L. Baker
Benton	Bob Huskins
Boone	John T. Troupe
	Charlton Chambers
Bradley	NOT REPRESENTED
Carroll	Shannon Card
Chicot	Homer K. Beavers
Clark	NOT REPRESENTED
Cleburne	NOT REPRESENTED
Columbia	NOT REPRESENTED
Conway	NOT REPRESENTED
Craighead-Poinsett	Robert D. Frey
	Joe H. Stallings
	Don B. Vollman
Crawford	NOT REPRESENTED
Crittenden	Steve P. Schoettle
Cross	Robert A. Hayes
Dallas	Jack Dobson
Desha	Howard R. Harris
Drew	NOT REPRESENTED
Faulkner	Jimmie J. Magie
Franklin	David L. Gibbons
Garland	Lee G. Atherton
	Brenda N. Powell
	Eugene M. Shelby
Grant	NOT REPRESENTED
Greene-Clay	Richard O. Martin
Hempstead	NOT REPRESENTED
Hot Spring	Greg Loyd
Howard-Pike	Robert R. Sykes
Independence	Lloyd Bess
Jackson	NOT REPRESENTED
Jefferson	Lee A. Forestiere
	Raymond A. Irwin, Jr.
	Anna T. Ridling

Johnson	NOT REPRESENTED
Lafayette	NOT REPRESENTED
Lawrence	Ralph F. Joseph
Lee	NOT REPRESENTED
Little River	NOT REPRESENTED
Logan	Sanford E. Hutson, III
Lonoke	NOT REPRESENTED
Miller	John A. Gillean
	Paul D. Meredith
Mississippi	Eldon Fairley
Monroe	NOT REPRESENTED
Nevada	NOT REPRESENTED
Ouachita	NOT REPRESENTED
Phillips	Robert D. Miller, Jr.
Polk	NOT REPRESENTED
Pope	James G. Burgess
	Frank M. Lawrence
Pulaski	Glen F. Baker
	Kelsy J. Caplinger, III
	Gilbert O. Dean
	Fred O. Henker, III
	Marvin Leibovich
	David Harshfield
	Frank M. Sipes
Randolph	NOT REPRESENTED
Saline	NOT REPRESENTED
Sebastian	John Lange
	William Schemel
	Paul I. Wills
	Rob Hughes
Sevier	NOT REPRESENTED
St. Francis	NOT REPRESENTED
Tri-County	Michael N. Moody
Union	Willis M. Stevens, Jr.
	Gary Bevill
Van Buren	NOT REPRESENTED
Washington	William B. Nowlin
	David L. Rogers
White	NOT REPRESENTED
Woodruff	NOT REPRESENTED
Yell	James L. Maupin
Resident Physician Section	NOT REPRESENTED
Medical Student Section	NOT REPRESENTED

Past Presidents

A. E. Andrews, John P. Burge, Asa A. Crow, C. Randolph Ellis, Ross E. Fowler, Albert S. Koenig, Jr; W. Payton Kolb, Ben N. Saltzman, Purcell Smith, Jr.; Joe Verser, Charles F. Wilkins, Jr.; and George Wynne.

Others attending were: Bob Benafield, David Busby, John Crenshaw, Peggy Cryer, William Dedman, James D. Foss, Mrs. John Guenthner, Elijah Harris, Nancy Kintzel, Ken LaMastus, Mike Mitchell, Rhys Williams, David Wroten, and Lynn Zeno.

Speaker Hart introduced the following guests and asked each to come to the podium and address the House: Mrs. Joe Ed Smith, Chairman of the AMA Auxiliary Legislative Committee; Mrs. W. Ray Jouett, President, AMS Auxiliary; and Mrs. J. Larry Lawson, President-elect, AMS Auxiliary.

AMA Auxiliary Address

Mrs. Joe Ed. Smith
Chairman, AMAA Legislative Committee

Greetings from the 75,000 members of the American Medical Association Auxiliary. Thank you for these few moments to tell you what we are doing on your behalf.

The ever-changing world in which physicians practice today brings new challenges to all who are part of the medical community. And that, of course, includes the people I represent. For while medical care in this country continues to be the best in the world, physicians are faced with myriad concerns which range from government involvement to professional liability to ethical issues brought by technological advances. AMA Auxiliary members share those concerns and we are convinced that we have the potential to make a difference on the difficult issues today if we renew our commitment to be involved in shaping those issues.

Commitment has long been the key to our success. Through the years our programs and projects to solve community health problems have benefited every age segment of society from the unborn to the elderly.

Most recently we have made adolescent health a major focus. We are pleased that last year our state and county auxiliaries implemented more than 1,000 programs to help the nation's youth.

This year we are working with the AMA on the HIV/AIDS youth education project and on a campaign to prevent teen pregnancy, sponsored by the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians.

Renewed commitment is also achieving results in the legislative arena as medical policy and decisions that affect you and your patients are increasingly made by legislative bodies. We are increasing our efforts to inform, educate, and update your members about the issues so that they are prepared to take action. Our phone bank system is in place, and the AMA has called for focused phone alerts this year to stimulate grassroots action. The committees that are focused are: House Ways and Means, House Energy and Commerce, Senate Finance and Senate Labor and Human Resources. The five member auxiliary legislation committee that I chair networks legislatively with the 50 states. As chairman, I also have the opportunity to attend the meetings of the AMA Council on Legislation. Our members are enthusiastic and effective players on medicine's legislative team. We are confident that we are making a difference.

We have also renewed our commitment to medical education. And this year we hope to exceed our $2 million goal in contributions to the AMA Education and Research Foundation which helps medicine attract the best and brightest minds.

Finally, we have renewed our commitment to helping our members and their families in stressful times. Across the

country, networks are quietly springing up to provide support in times of crisis. At the national level, we continue to provide the impetus for these networks and to expand our series of booklets on issues unique to the medical family. The newest booklet will explore the assets and liabilities of spouses who work in the physicians' offices.

Of course, our ability to achieve our goals is due to our partnership with you, the physicians of this nation. We thank you for your support and for the opportunities to work side-by-side with you. You have put your confidence in us and you will not be disappointed. Because working together with renewed commitment to our cause will reach the potential that is within us to help you see that quality care continues to be available to every American. Thank you.

Auxiliary President's Address

Mrs. W. Ray Jouett

Madam Speaker, Dr. Hestir, Dr. Weber, and the House of Delegates: I bring you greetings from 1,013 Arkansas Medical Society Auxiliary members. This has been a year that we have placed emphasis on working together from the grassroots up, to be involved, informed, and participating.

We began our year working with the Arkansas Medical Society at the Health and Fitness Expo '88, handing out our newly off-the-press AIDS Directory and assisting the Society in handing out AIDS packets and public relations materials.

The Auxiliary Board of Directors planned their grassroot strategy for the year in September. We formed a travel team of informed workshop leaders who would go to the four districts of the state and give a workshops on legislation, health projects, membership, and AMA-ERF fund raising. We were greatly assisted by Mr. Lynn Zeno with the legislative part. We were graciously received in Jonesboro, Pine Bluff, Texarkana and Fayetteville.

We put together material for a brochure to support the Physicians' Health Committee and started a group of volunteers who have had experience in fielding hotline calls, who will be responsive to a Arkansas Medical Society Auxiliary Hotline.

We developed an information booklet, "Understanding Medical Liability Claims." This booklet is full of pertinent facts that would be helpful to a physician or spouse if a malpractice suit occurred.

County auxiliaries have been busy with numerous health projects: vision screening, scolosis screening, health fairs, play hospital education, baby sitting training; providing educational resources about AIDS and teen pregnancy; printing and distributing teen crisis cards; one county is publishing a comprehensive teen crisis booklet; fund raising for MedCamps; numerous scholarships and AMA-ERF.

We are working on a state-wide DWI project which will take two years to complete and will begin this fall. This project will be partially supported by the medical society, and physicians will be advising our core DWI Committee.

I would be remiss if I did not thank the medical society for your financial support. We use these funds to supplement the funds we budget for delegates to AMA Auxiliary meeting and to AMA Auxiliary Confluence. These meetings and workshops are a great source of encouragement to our delegates and participants. The remainder of funds are spent to produce or print resource material. We also want to thank the medical society staff for their splendid support and encouragement.

This year the auxiliary will have a special table in the exhibit hall to display projects from different county medical auxiliaries. We invite you to stop by and learn more about how we spend some of our precious time.

Again, let me thank you for your encouragement and your support. We are making our plans to focus on the future.

Auxiliary President-Elect's Address

Mrs. J. Larry Lawson

Ladies, Gentlemen, and Delegates: In 1925, 203 ladies met in this same hotel for the very first time. Their purpose was "to extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement in health and education, to assist in entertainment in all medical conventions, and to promote acquaintanceship among doctors' families so that closer fellowship may exist."

Although little has changed in the purpose, much has changed in the area of membership. Today our organization boasts of over 1,000 who are working to fulfill the same objectives.

While preparing for this speech, I reread letters from several past presidents of the Arkansas Medical Society to presidents of the Arkansas Medical Society Auxiliary. Drs. Crow, Wilkins, Hestir and Jouett all stressed that the Auxiliary should be involved in the legislative process. Dr. Weber, the soon-to-be president, took this idea one step further and urged us to become involved on a grassroots level.

So, members of the society, I promise that the Auxiliary will be better informed and more visible in the legislative process. We will secure a strong base with our local representatives in the political arena so as to have an avenue of communication enabling us to educate them on the needs and posture of medicine.

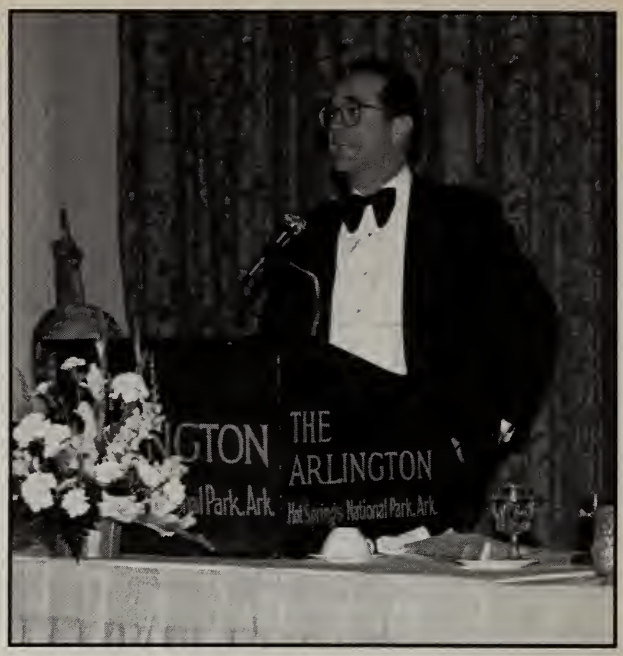
Drs. Jouett and Weber touched on an area of concern that is important to me, being a school board member and a former teacher - education. We will continue our efforts to educate adolescents in the area of teen pregnancies, teen suicide, and substance abuse.

Our newly formed committee on drunk driving will be an important aspect of our education efforts in 1989-90. Also continuing is our support of the family during times of stress with the Auxiliary hotline. We are grateful for the help we have received for these projects from the medical society.

Thank you for the opportunity to work with you and feel free to involve the auxiliary in any effort you undertake, remembering that this is indeed a joint effort. I would like to ask the Society to encourage your wives to share their volunteer time with the Auxiliary. This year we increased our membership by eight percent. Next year, I hope it is increased by ten percent, and more importantly, that the active participation of these members approaches one hundred percent.



Above: James Weber, M.D., takes the oath of office and assumes the presidency of the Arkansas Medical Society .



Above: Mr. Joe Griffith of Dallas, TX, kept the crowd in stitches (pardon the pun) with his humorous stories.



Right: Dr. John M. Hestir, of DeWitt, took a few moments to reflect on the accomplishments and progress of the Arkansas Medical Society during his presidency.



Left: Congressman Tommy Robinson was among the distinguished guests at the Inaugural Banquet. Congressman Robinson read a letter from United States President George Bush congratulating Dr. Weber on his election.

Speaker Hart asked President John Hestir to come to the podium to address the House.

President's Address

John M. Hestir, M.D.

Madam Speaker, Delegates, Auxiliary and Guests: I bring you a report today of one of the most successful years of the Arkansas Medical Society. This success has mainly been contributed to the able guidance of Ken LaMastus and an excellent staff. Also, the approval and acceptance of the doctors of the state of Arkansas added the Department of Governmental Affairs to your medical society. It has even been more rewarding since the doctors have endorsed and subsidized this addition of the medical society. This is indicated by the fact that there has been a continued increase in enrollment of the membership of the medical society.

Through the first year of the Department of Governmental Affairs, there has been a number of significant firsts.

The malpractice insurance rate increase of 19% which was applied for by St. Paul, contested for the first time by the medical society through the Department of Governmental Affairs under the direction of Lynn Zeno. It was challenged in front of the insurance commissioner. He got a review of their request for a rate increase and a reduction that has saved the doctors of Arkansas $1.1 million per year. I feel this will have a significant effect on insurance companies asking for rate increases in the future.

Another first for our medical society has been the increased political activity and success in the state legislature by your Department of Governmental Affairs. Of 140 bills which pertained to medicine, we were virtually successful in all but two.

Of these bills, your Department of Governmental Affairs, lobbyists, and the doctors in Arkansas worked diligently with their legislators. These two bills were passed by the House and the Senate and sent to the Governor and then promptly vetoed. I feel this is also a first for the medical society in that we got two sponsored bills passed and were vetoed.

Another first for your medical society, and one I feel is monumental, is the acceptance of the Indigent Care Plan in the state of Arkansas. It is known as the Arkansas Care Access Foundation. This was passed unanimously by you, the House of Delegates. The doctors of Arkansas have again accepted the challenge and this foundation is rapidly becoming a reality under the able guidance of Dr. Asa Crow and his committee. As you know, doctors receive the blunt of criticism from newspapers and politicians for not taking care of the indigent. I have often wondered, who has taken care of the indigent? They have always been taken care of by the doctors of the state of Arkansas. By accepting this plan and putting it into effect, we the doctors of Arkansas, will get our just dues and this plan will not impose a great strain on anyone. In the first year of the Kentucky plan, there was only an average of 2.8 indigent patients per doctor seen in the state of Kentucky. They have twice the indigent population that we have in Arkansas.

During this session of the Arkansas Medical Society you will receive the report of the Long Range Planning Committee. This plan has been in development for approximately 30 months. Its aim and function is to bring the medical society up to date and to recommend the strategies for the Arkansas Medical Society to address the needs and changes of environmental forces affecting the medical profession. The report of the Long Range Planning Committee has been mailed to members of the medical society. I hope you have studied this report. It will be submitted to a reference committee for evaluation, suggestions, and hopefully, approval.

In my inaugural speech one year ago, I mentioned the continuous problems and complaints from the doctors throughout the state of Arkansas about the actions of the Arkansas Foundation for Medical Care. I addressed this issue and stated at that particular time that the Arkansas Medical Society has no function and no input in the Foundation. This foundation is made up of the doctors of the state of Arkansas. I said at that time that if the doctors are unhappy with the activities of the Foundation then they should become active in the Foundation and seek input in the Foundation. Run for office in the Foundation. It was reported at the Board of Directors meeting the next day, that I said all of the Board of Directors should be replaced. This certainly was not true.

The complaints over the year have continued to increase. In September, 1988, Mr. Gene Hartsell, Executive Director of the Arkansas Foundation for Medical Care asked me to form a liaison committee to work with the Foundation for better communications between the Foundation and physicians of Arkansas. I accepted his request and appointed a committee which consisted of Pat Hazzard, David L. Rogers, H. Nunnally, Paul I. Wills, and Ray Jouett, who was elected chairman of this committee. I also requested from the Foundation that a copy of the minutes from the Executive Committee and the Board meetings for the past three years, along with the financial statements, be forwarded to this committee. It is the policy, and has been so stated from HCFA, that all financial statements and minutes are available to members of the PRO in all of the states. This information has not been forwarded to the chairman of the committee. This has been followed up with two letters from the committee requesting the same information, plus a list of the members of the Arkansas Foundation. This material has not been furnished to the committee at this point. The last request was in January of 1989.

In February, 1989, a reply was received from Mr. Hartsell stating that as soon as all sensitive and confidential information could be removed, the information would be furnished. At the present time, this information has not been furnished.

Mr. Hartsell was invited to attend the meetings of the Liaison Committee, but he has not responded to that request. A meeting was arranged between different liaison committees including the Arkansas Medical Society and the Arkansas Hospital Association in February, 1989, at the request of Mr. Hartsell. At this time, a discussion was presented concerning Medicare and Medicaid programs' denial of payment for substandard beneficiary complaints. It was the desire of Mr.

Hartsell that everyone become involved in trying to prevent, if possible, the implementation of the regulation concerning this matter.

The Committee has met on two other occasions without the benefit of any representative designated by Mr. Hartsell and the Committee has looked at several problems with the Foundation and it is the consensus of opinion that there are problems with the Foundation. The report of this committee will be presented to the reference committee for your information and comment. It was also the feeling of the Committee that this is a problem that needs to be addressed through the members of the Foundation and it is not a problem that needs to be addressed on the Arkansas Medical Society level.

The following points are issues that the Liaison Committee feels need to be addressed and the recommendations made to the Board of Directors.

1. Information needs to be disseminated to the Arkansas Foundation members that this is a very important organization and that they should make their influence and presence known concerning the election of the board of directors. They should be actively involved in the election of board members and should make the annual meeting a high priority. Information has also come to the committee that the executive committee does not present minutes of their meetings, therefore, they are not supplying the information for the board's attention as directed by their bylaws and as a result the action of the executive committee is not approved by the complete board. It would be the recommendation of this committee that that information be placed before the complete board.
2. Appointment of a chairman of the board should be ratified by the entire board.
3. A recommendation should be made to the complete board that the Arkansas Foundation for Medical Care should refrain from bidding on other contracts outside of Arkansas. Information has been received that the Arkansas Foundation for Medical Care has either considered or has placed bids for Oklahoma and Louisiana PRO.
4. That the annual meeting of the Arkansas Foundation for Medical Care coincide with the annual meeting of the Arkansas Medical Society.
5. That the remuneration for reviewing physicians should be increased and also that they have more time to complete reviews of charts.
6. That the PRO become more involved with educating the physician and become less aggressive as a punitive body.
7. That there be more open communication between the PRO and the physicians of the state. All information of a non-restricted nature should be freely given to anyone who is interested and to all qualified members of the Foundation as stated and required by HCFA.
8. That the board be informed that it is not the aim nor desire of the Arkansas Medical Society to become involved with the PRO and certainly to also express that it is not the desire of the medical society to interfere, change, or try to destroy the effectiveness and functioning of the Foundation and the PRO. Also that the medical society understands that the PRO must function and that this is something we all need to survive in the most distressing form of government bureaucracy.

What I have presented to you are, I feel, the most important functions of the Arkansas Medical Society in the past year. I think that this is just the beginning of success, recognition, and indications of what the medical society can and will do in the future. The staff has done an extremely superior job this year under the leadership of Ken LaMastus. They certainly need a well-deserved recognition and praise. I'm sure that the medical society will even do better this next year with the able guidance and direction of Dr. James Weber. This is only a tip of the iceberg. Thank you.

Upon a motion, which was seconded from the floor, the minutes of the 112th House of Delegates were approved as printed in the June 1988 issue of the *Journal of the Arkansas Medical Society*.

Upon a motion which was seconded from the floor, the minutes of the October 9, 1988 House of Delegates were approved as printed in the December 1988 issue of the *Journal of the Arkansas Medical Society*.

Speaker Hart asked President Hestir to come to the podium for the AMA-ERF presentation. Dr. Hestir asked Mrs. Ray Jouett, Mrs. Robert Hughes, AMA-ERF Chairman; and Dr. Glen Baker, representing UAMS to come to the podium. Dr. Hestir presented two checks to Dr. Baker on behalf of the AMA Education and Research Fund. One check for $4,177.06, intended for the pursuit of excellence in the Medical Schools program, was given for unrestricted use. The other check, in the amount of $17,216.84, restricted to the school's program for financial assistance to medical students, was also given to Dr. Baker.

On behalf of UAMS, Dr. Baker thanked the AMS and Auxiliary for their work and support.

Speaker Hart reviewed the four items of business received in the Society office twenty days prior to the meeting but after the March *Journal* deadline. They are as follows: PRO Liaison Committee Report, Ninth Councilor District Report, Resolution from the Pulaski County Medical Society Concerning Third Party Payors and the Long Range Planning Committee Report. Each item is printed in this issue of the *Journal of the Arkansas Medical Society* on page .

Speaker Hart announced that for new business to be introduced from the floor, two-thirds consent from those in attendance would be required. She then asked if there was any such business to be introduced. William Jones, Little Rock, asked to be recognized to present a resolution from the Pulaski County Medical Society supporting the efforts of the New York State Medical Society's resolution on AIDS which states:

Resolution Concerning the Medical Society of the State of New York AIDS Resolution

WHEREAS, the Medical Society of the State of New York will introduce a resolution at the Annual Meeting of the AMA House of Delegates in June which will urge the AMA to take formally the position that AIDS is a communicable/sexually transmissible disease by asserting:

(1) That states should apply the same public health measures to contain the HIV epidemic as are taken to control the spread of other communicable/sexually transmissible disease and

(2) That no restrictions should be imposed by states on physicians' medical judgements in the testing for the presence of HIV infections as is currently the case for testing for other communicable/sexually transmissible diseases.

RESOLVED, that the Arkansas Medical Society supports and commends this effort on the part of the Medical Society of the State of New York.

Upon a motion from Charles Logan, which was seconded, the House of Delegates voted to accept the resolution as new business.

Dr. Jones asked that a copy of the Pulaski County Resolution be mailed to the New York State Medical Society and the AMA House of Delegates to be presented at their annual meeting in June, assuming the AMS House of Delegates passes it during the final meeting.

Dr. James Maupin made a motion which was seconded, that the resolution also be mailed to the State Board of Health.

Speaker Hart reminded members from the Third Congressional District to meet during the recess of the House of Delegates to select a nominee to fill the open position on the State Medical Board. Dr. Rhys Williams is currently serving in that position and is eligible for reappointment. Counties in the Third Congressional District are: Baxter, Boone, Carroll, Crawford, Franklin, Johnson, Logan, Madison, Marion, Newton, Scott, Searcy, Sebastian, Van Buren and Washington.

Speaker Hart announced the names of the new nominating committee delegates for the councilor districts. They are: District #1, Richard O. Martin, M.D., Paragould; District #3, Samuel A. McGuire, M.D., Forrest City; District #5, Raymond N. Bowman, M.D., El Dorado; District #7, Brenda N. Powell, M.D., Hot Springs; and District #9, David L. Rogers, M.D., Fayetteville.

She reminded the committee as a whole to meet immediately following the House of Delegates to select officers for the coming year.

Following the announcement of times and places for reference committees to meet, the House was adjourned until Saturday, April 29, at 3:30 p.m.

INTERNIST NEEDED
MORRILTON MEDICAL CLINIC

The Morrilton Medical Clinic, P.A., is looking for a board certified/eligible internal medicine specialist. Salary and partnership negotiable. Benefits available. Staff and computer system furnished, pharmacy located in clinic. Three FPs and one IM currently on staff.

The clinic is located within walking distance of Conway County Hospital, an 84-bed facility. The growing community of Morrilton has an excellent school system and is 50 minutes from Little Rock. There are excellent recreational activities in nearby Petit Jean State Park with hunting and fishing available. Send resume to:

Marlin L. Boyle, Administrator
Morrilton Medical Clinic, P. A.
#10 Hospital Drive
Morrilton, Arkansas 72110
(501) 354-0052

The following reports were received in the Society office headquarters after the publication of the March 1989 *Journal of the Arkansas Medical Society.*

Long Range Planning Committee Report

Lloyd Langston, M.D., Chairman

INTRODUCTION

The purpose of the Long Range Planning Committee has been to evaluate the environmental forces affecting the medical profession, identify physicians' needs that have been created by these forces, and to recommend strategies for the Arkansas Medical Society to address these needs. The result is a set of goals that if pursued, will provide the focus for AMS policies, programs, and activities for the foreseeable future.

An environmental analysis clearly points out the complex and dynamic nature of todays' medical profession. Physicians are constantly faced with outside pressures from many directions. The business and economic aspects of practice are more complex and less understandable than ever. As a result of increased government control, and interference by third parties the physician has suffered a loss of autonomy. The explosion in technology presents new and better ways to save lives, but also keeps constant upward pressure on the cost of care. At the same time there are constant pressures from insurers and business to reduce costs.

As our environment changes, so too, do the needs of physicians. Todays' physicians have a stronger need for representation and advocacy than ever before. A strong advocacy program is necessary if physicians are to be represented in the decisions taking place in government and private industry that ultimately affect them and their patients. Todays' physicians also need to develop better practice management skills, and they need current information on socioeconomic issues and ethics. Other needs of lesser priority were identified such as professional image, psycho-social support, leadership training and scientific information.

Representation and advocacy emerge as the most critical needs of physicians. The AMS has a long history as the primary responder to these needs. However, the complexities that characterize todays environment threaten to overwhelm this ability if we become spread too thin by trying to be all things to all people. ***To prevent this the AMS must focus its attention on enhancing its role as a representative of the profession.***

The AMS can rely on several strengths to accomplish this mission. The AMS has a strong financial base, good credibility, strong staffing and communications tools. The AMS needs a more representative membership base, greater involvement of its members, and more influence and exposure to decision makers and stakeholders in medical issues. In addition, the AMS needs to strengthen its organizational structure and political programs. It must focus its educational and communication programs on priority needs and insure the long term financial stability of the organization.

GOALS

THE LONG RANGE PLANNING COMMITTEE RECOMMENDS THAT THE AMS PURSUE THE FOLLOWING GOALS AND FOLLOW THE STRATEGIES PRESENTED FOR THEIR SUCCESS.

GOAL #1

PURSUE PROGRAMS AND POLICIES THAT WILL STRENGTHEN THE AMS MEMBERSHIP BASE

Strategies for Success

A. Focus recruitment efforts on medical students and young physicians.
   1. Develop better access to medical students and residents.
   2. Fully inform prospective and new members about their dues exempt status and its implications.
   3. Increase medical student awareness of M.E.F.F.A. and its benefits.
B. Review county medical society membership and billing policies and make recommendations to adopt a more uniform, streamlined procedure.
C. Develop alternative dues payment methods such as credit cards and semiannual payment.
D. Provide a mechanism to allow physicians the option to join AMS directly, rather than through the county society. Provide the counties an opportunity to review applicants for direct membership.
E. Evaluate the reasons physicians have for not joining and use this information to recommend changes in future programs or benefits.
F. Develop new or improve existing benefits and services that address priority needs of physicians.
G. Build a stronger relationship with the Dean and other physicians at the University of Arkansas College of Medicine.

GOAL #2

INCREASE THE LEVEL OF INVOLVEMENT OF AMS MEMBERS IN AMS ACTIVITIES AND PROGRAMS.

Strategies for Success

A. Promote grassroots participation in AMS legislative programs.
   1. Develop active contacts and political educational programs with AMS subgroups.
   2. Identify and provide interested local members an opportunity to participate when possible, in state and federal political affairs.

3. Encourage and help coordinate political activities with the Auxiliary.
4. Develop a mechanism to solicit participation of new and current members on AMS committees and task forces.

B. Work closely with the specialty societies on key issues and encourage their use of the AMS specialty desk.
C. Develop programs for the AMS Annual Session that address the priority needs of members.
D. Develop programs for the AMS Annual Session that will encourage attendance of AMS subgroups (i.e. medical students, residents and especially young physicians).
E. Develop leadership building programs for young physicians.This should include funding a delegate and alternate delegate to the AMAYPS meetings and one young physician representative to the AMA Leadership Conference.

GOAL #3

BUILD GREATER CREDIBILITY WITH THOSE GROUPS, ORGANIZATIONS, AND INDIVIDUALS THAT ARE DECISION MAKERS OR STAKEHOLDERS IN ISSUES AFFECTING THE MEDICAL PROFESSION.

Strategies for Success

A. Improve communications with elected officials and agencies.
   1. Develop grass root support for legislators beginning before their election and continuing throughout their term of office.
   2. Increase participation of individual AMS members in local campaigns.
   3. Encourage attendance of individual AMS members at legislative sessions and meetings.
   4. Provide intensive political education programs to AMS members and Auxiliary.
   5. Prior to each legislative session outline our legislative agenda and explain our position on major issues to each legislator. This could be accomplished via audio cassette.

B. Create opportunities for positive exposure tothe public.
   1. Provide speakers for public and civic groups.
   2. Develop public service messages on key health issues.
   3. Produce brochures on key health and socioeconomic issues for distribution in physicians offices.

C. Identify and work with key organizations and allied health groups such as the Arkansas Hospital Association, Arkansas State Nurses Association, the AARP, labor/employee groups and business organizations on issues of mutual concern.
   1. Allow these organizations a forum in the JAMS, to present their views on issues of mutual concern.
   2. Consider the development of an AMS group whose purpose would be to write articles on key issues for the publications of these identified groups.
   3. Consider creating an "allied health coalition" to foster one-on-one discussion on issues of mutual concern.

D. Develop programs to improve communications with and more favorable exposure to the media.
   1. Create a key contact program in each locality to serve as a personal link between AMS and the media.
   2. Establish a statewide speakers bureau with access to the media.
   3. Provide the media with background information from AMS and AMA on key issues.
   4. Utilize public service time when available for stating AMS positions on key issues and consider purchasing space or air time when necessary.

GOAL #4

IMPROVE THE ORGANIZATIONAL STRENGTH AND EFFECTIVENESS OF THE AMS.

Strategies for Success

A. Create a Governmental Affairs Council (GAC) to oversee the Department of Governmental Affairs.
   1. Would replace and assume the responsibilities of the Committee on Medical Legislation, Subcommittee on National Legislation, State Legislative Fund Committee and AMSPAC Board of Directors.
   2. The GAC would initially consist of 3 AMS members from each Congressional district (appointed by the AMS president), AMSA President, and the AMSA Legislative Chairman.
   3. Members would serve for three (3) years with a maximum of two (2) consecutive terms and staggered so one member from each district is replaced yearly.
   4. The GAC shall elect a chairman and vice chairman each year.
   5. Responsibilities of the GAC:
      (a) Report the activities of the Department of Governmental Affairs to the AMS Council, House of Delegates, and membership.
      (b) To assist political action groups of the local medical societies in local, state and federal campaigns.
      (c) To plan and assist in fund raising as needed and to oversee the expenditure of funds.
      (d) To provide or develop local key contacts with local, state and federal elected officials.
      (e) To develop a key contact list with individuals representing the various specialties in each county.
      (f) Other responsibilities as may be necessary.
      (g) Hold quarterly meetings to carry out its duties.

B. Create a Governmental Affairs Steering Committee as a Subcommittee of the GAC.
   1. Would consist of three members elected by the GAC, one of which must be the Chairman of the GAC.
   2. Would work closely with the Director of the Department of Governmental Affairs.
   3. Power to make emergency decisions in consultation with the Director when time is of the essence.
   4. Would meet as needed to assist and consult with the Director.

5. Members can be replaced at any time by vote of the GAC.
6. Would report any actions taken to the GAC at regular quarterly meetings.

C. Appoint a special task force to thoroughly study The AMS Constitution and Bylaws and recommend necessary changes to update it.
D. Improve the effectiveness of the AMS Committee system.
1. Abolish all committees that have no function or activity.
2. Adopt a sunset provision for all committees.
3. Utilize task forces for specific problems and key issues.
4. Delete from the AMS Constitution, all required committees except Nominating, Executive and Budget.
E. Improve attendance of Councilors and other elected or appointed officials at AMS meetings.
1. Add a section to the AMS Constitution to provide that any office, committee member, or other elected or appointed official, missing a specified percentage or number of the regular meetings during the year of the body on which they serve, shall be presumed to have resigned.
F. Provide activities and programs to buildleadership skills for officers and councilors.
G. Encourage county societies to explore areas of concern and present them as resolutions for AMS action.
H. Direct the Budget Committee to study the possibility of providing some type of financial consideration to the AMS President to compensate for time spent away from practice.
I. Prepare a report on turnover of AMS officers and councilors and consider recommendations to limit lengths of office.
J. Continue the current scheduling of Council meetings and House of Delegates meetings.

GOAL #5

FOCUS EDUCATIONAL AND COMMUNICATION PROGRAMS ON IDENTIFIED KEY ISSUES FACING THE PROFESSION.

Strategies for Success

A. Provide seminars and other educational activities on practice management, socioeconomics, financial planning, and other identified areas of key concern.
B. Provide educational programs to AMS members and Auxiliary on the political process and their responsibility to become involved.
C. Consider the occasional publication of a larger Newsletter to contain more indepth explanations and background on important issues.
D. Change the direction of the Journal of the Arkansas Medical Society. The Journal should:
1. Provide a forum for Arkansas physicians to present their views and concerns.
2. Address primarily socioeconomic, political/legislative, and medical/legal issues.
3. Provide an analysis of state and national legislative proposals and regulations.
4. Contain reports from the AMA relevant to legislative and socioeconomic issues.
5. Publish proceedings and important decisions of AMS.
6. Publish proceedings of the Arkansas State Medical Board, excluding the names of physicians for whom no action was taken.
7. Encourage component societies to publish news and reports.
8. Create a "Letter to the Editor" section, and solicit unusual case reports.
9. Publish a limited number of scientific articles and consider limiting this to semiannual editions.
E. Monitor the organizations currently investigating or developing standards of care.
F. Increase the Society's involvement in medical ethics. Direct the Professional Relations Committee to meet periodically with the State Medical Board to discuss each of their roles.

GOAL #6

INSURE THE PRESENCE OF A SOLID, FINANCIAL BASE FROM WHICH TO ACCOMPLISH AMS GOALS.

Strategies for Success

A. Establish a financial reserve policy of 6 to 12 months operating expenditures.
B. Reduce the percentage of total revenue coming from membership dues by pursuing more opportunities for non-dues income.
C. Review the distinction between Life and Emeritus membership and consider charging a percentage of regular dues to this group.
D. Increase the percentage of members contributing to AMS political fundraising efforts.
1. Create a single fundraising entity by combining the current AMS Political Action Committee and AMS State Legislative Fund into a new Arkansas Medical Society Legislative Fund (MEDPAC).
2. The duties of the current State Legislative Fund and AMSPAC Board would be assumed by the Governmental Affairs Council.
3. Utilize a one-time annual solicitation included on the AMS dues statement and if necessary subsequent solicitations in conjunction with the AMA (as currently practiced).
4. The recommended contribution would be $100, split for federal and state use.
E. Make the *Journal of the Arkansas Medical Society* more self supporting.
1. Discontinue the "Physicians' Directory" section of the *Journal* which loses money.
2. Encourage physicians who want to support the *Journal* or run advertisements to do so, but at the regular commercial rate.

Epilogue

(The following is an excerpt from the Subcommittee on Public Relations and Communication.The Long Range Planning Committee felt that the message was very important and that it should be included with this report.)

It is the consensus of this sub-committee that the essential element of public relations and communication rests squarely on the individual physician. Whether or not we enjoy the role, we are in fact inescapably cast in it. We know that the individual physician, with few exceptions, stands high in the esteem of his or her patients and is a highly respected member of the community. Unfortunately, the corporate body known as the medical profession has lost a substantial amount of respect and good will from the public at large over the past several years. Problems such as the cost of medical care, quality of care and access to care, bedevil the patient. We are perceived as responsible. Are we? Failure to inform patients concerning diagnosis, treatment, risks, and medication side effects, fail to meet expectations of a better informed public. Aggravations such as long periods of waiting in our offices cause resentments which are not soon forgotten.

Empathy and compassion for patients and families creates supporters instead of detractors. We can do better. By and large we do better than these examples. Will we simply remember, "If it is to be, it is up to me"?

(This report was discussed in Reference Committee #3. Recommendations from that committee are included in the final House of Delegates report.)

Ninth Councilor District

R. H. Langston, M.D., Councilor

The Ninth Councilor District welcomed Dr. Warren Murry as a junior councilor.

Primary concern of the Ninth Councilor District during 1988 had been in the area of third party control of a practice of medicine. This includes the federal and state government as well as peer review of the Arkansas Foundaton of Medical Care (PRO). The Boone Docs (Boone County Medical Society Governmental Affairs Committee) sponsored a legislative appreciation dinner for legislators in our area with Mr. Lynn Zeno of the Arkansas Medical Society governmental affairs office expressing apreciation of the physicians of Arkansas to our representatives. In addition, they sponsored the second annual legislative appreciation fish-fry with most of the business leaders as well as locally elected representatives and others interested in political action invited. Also, a reception for John Paul Hammerschmidt was held at the North Arkansas Community College raising over $12,000 for his campaign fund. Similar receptions were sponsored in Washington and Sebastian counties. Although significant contributions were made by local physicians, many other community leaders contributed significant amounts. Finally, the committee supported the successful campaigns of all the local legislators. As a result of these activities, it is our hope that physicians will at least be heard by their legislators.

The other area of concern is with the Arkansas Foundation for Medical Care and its impact upon the rural hospitals of our district, as well as our individual practices. With the Oklahoma physicians winning their contract back under re-bidding process, the Board of the Foundation should be convinced that the staff's statement, "we will lose our contract" is exaggerated. Hopefully, this will allow the PRO board to become slightly more lenient in the favor of our hospitals and our patients. It is not intended that the Arkansas PRO be "number one" in HCFA's eyes. Continued effort in liaison with the Foundation for Medical Care by your Arkansas Medical Society is essential.

Resolution from the Pulaski County Medical Society Concerning Third Party Payors

Whereas, third party payors have started aggressive campaigns to alter the public's freedom to choose its physicians, the locations of provision and the conduct of medicare care, and

Whereas, the Federal government, through the Department of Health and Human Services, the Health Care Finance Administration and its peer review organizations (PROs) is regulating the access to providers of medical care for Medicare beneficiaries; therefore be it

RESOLVED, that the Arkansas Medical Society actively pursue legislative and public policies to protect the free exercise of the doctor-patient relationship and see freedom from interference of medical judgement by third party payors, including the Federal Government.

PRO Liaison Committee Report

W. Ray Jouett, M.D.

In September 1988 a request was made by Mr. Gene Hartsell, executive director of the Arkansas Foundation for Medical Care, to the Arkansas Medical Society to form a PRO Liaison Committee from the Arkansas Medical Society to the Foundation. This committee was appointed by Dr. John Hestir, President of the Arkansas Medical Society, and was composed of Marion P. Hazzard, David L. Rogers, H. Nunnally, Paul I. Willis and Ray Jouett.

The request for this committee from Mr. Hartsell was directed toward better communication between the Foundation and the physicians of Arkansas. Dr. Hestir requested of Mr. Hartsell in October 1988 that the committee be sent a copy of the last three years Executive Committee minutes, Board minutes and audited financial statements. The information was not forwarded and the Chairman of the Committee also has followed up with two letters requesting the same information plus a list of the members of the Arkansas Foundation and that material has not been furnished the committee to this point. The last request was in January 1989.

In February 1989 a reply was received from Mr. Hartsell stating that as soon as all the sensitive and confidential nature

of the material could be removed that the information would be furnished. To the present time that information has not been furnished.

Mr. Hartsell was invited to attend the meeting of the Liaison Committee but he has not responded to that request.

A meeting was arranged between the different liaison committees including the Arkansas Medical Society and the Arkansas Hospital Association in February 1989 at which time a discussion was presented concerning medicare and medicaid programs denial of payment for substandard beneficiary complaints. It was the desire of Mr. Hartsell that everyone become involved in trying to prevent, if possible, the implementation of the regulation concerning this matter.

The Liaison Committee has met on two occasions without the benefit of any representative designated by Mr. Hartsell and the committee has looked at several problems with the Foundation and it is the concensus of opinion that the PRO is no longer under the control of the Board of Directors and that this is of great concern to members of the Foundation.

It was also the feeling of the committee that this is a problem that needs to be addressed through the members of the Foundation and it is not a problem that needs to be addressed at the Arkansas Medical Society level.

The following points are issues that the Liaison Committee feels need to be addressed and the recommendations made to the Board of Directors.

1. Information needs to be disseminated to the Arkansas Foundation members that this is a very important organization and that they should make their influence and presence known concerning the election of the Board of Directors. They should be actively involved in the election of board members and should make the annual meeting a high priority. Information has also come to the committee that the Executive Committee does not present minutes of their meeting and, therefore, they are not information for the Board and also as a result are not approved by the complete Board. It would be the recommendations of this committee that the information be placed before the complete board.
2. Appointment of the Chairman of the Board should be ratified by the entire board.
3. A recommendation should be made to the complete board that the Arkansas Foundation for Medical Care should refrain from bidding on other contracts outside of Arkansas. Information has been received that the Arkansas Foundation for Medical Care has either considered or has placed bids for Oklahoma and Louisiana.
4. That the annual meeting of the Arkansas Foundation for Medical Care to coincide with the annual meeting of the Arkansas Medical Society.
5. That the remuneration for reviewing physicians should be increased and also that they have more time for complete review of charts.
6. That the PRO become more involved with educating the physician and become less aggressive as a punitive body.
7. That there be more open communication between the PRO and the physicians of the state. All information of a non-restricted nature should be freely given to anyone who is interested and all qualified members of the Foundation.
8. That the board be informed that it is not the aim nor desire of the Arkansas Medical Society to become involved with the PRO and certainly to also express that it is not the desire of the Medical Society to interfere, change or try to destroy the effectiveness and function of the Foundation and the PRO. Also that the Medical Society understands that the PRO must function and that this is something we all need to survive in this most distressing form of government bureaucracy.

PHYSICIAN WANTED

Two young FP's seeking 3rd partner to join busy practice, including OB services, in south Arkansas. Population of 15,000 within a five mile radious; 27,000 in service area. Must be board certified. Guaranteed first year salary with opportunity for ownership after one year. Variety of recreational opportunities, excellent school system, and family-oriented community. Please call Phyllis Reeder at (501) 364-9111.

SUPPORT PAC!

Call or write the Society office to find out how.

Arkansas Medical Society
Post Office Box 5776
Little Rock, Arkansas 72215
(501) 224-8967
or outside Little Rock
1 (800) 542-1058



The Silent Auction, sponsored by the Auxiliary, was a huge success with $3,300 raised for AMA-ERF. The Presidents' Reception, held in conjunction with the auction, was sponsored by the Medical Protective Company.



Guests were intrigued by the many auction items available. Among them was a dinner cruise on the Arkansas River, a duck hunting trip, and a weekend at the dog races.



The display of the Who-Dun-It Dinner for Six was a favorite of the Silent Auction crowd.



A group of over 300 listened attentively to the speakers at the Shuffield Award Luncheon and Lecture.



The band "Private Practice" kept everyone on their toes until the wee hours with music from the 50's through the 80's.

Final Session
House of Delegates
April 29, 1989

Vice Speaker of the House, James Gardner, called the meeting to order at 3:30 p.m., Saturday, April 29, 1989. He asked that Charles Wilkins come forward to give the invocation.

Members of the Society seated as officers, councilors, and delegates were:

Officers

James Gardner, John M. Hestir, W. Ray Jouett, James M. Kolb, Jr.; Charles Rodgers, James R. Weber.

Councilors

District 1	Merrill J. Osborne
	J. Larry Lawson
District 2	Jim E. Lytle
	John E. Bell
District 3	Hoy B. Speer, Jr.
	L. J. P. Bell
District 4	Lloyd G. Langston
	Paul A. Wallick
District 5	NOT REPRESENTED
District 6	NOT REPRESENTED
District 7	Ronald J. Bracken
District 8	Paul Cornell
	William N. Jones
	Charles Logan
District 9	Robert H. Langston
District 10	Gerald Stoltz
	Morton Wilson

Delegates

Arkansas	Dennis Yelvington
Ashley	NOT REPRESENTED
Baxter	Robert L. Baker
	John F. Guenthner
Benton	NOT REPRESENTED
Boone	John T. Troupe
	Charlton Chambers
Bradley	Joe H. Wharton
Carroll	Shannon Card
Chicot	NOT REPRESENTED
Clark	NOT REPRESENTED
Cleburne	NOT REPRESENTED
Columbia	NOT REPRESENTED
Conway	NOT REPRESENTED
Craighead-Poinsett	Robert D. Frey
	Joe H. Stallings
	Don B. Vollman
Crawford	NOT REPRESENTED
Crittenden	Steve P. Schoettle
Cross	Robert A. Hayes
Dallas	Jack Dobson
Desha	Howard R. Harris
Drew	NOT REPRESENTED
Faulkner	Jimmie J. Magie
Franklin	David L. Gibbons
Garland	Lee G. Atherton
	Brenda N. Powell
Grant	NOT REPRESENTED
Greene-Clay	Dwight Williams
Hempstead	James Branch
Hot Spring	NOT REPRESENTED
Howard-Pike	Robert R. Sykes
Independence	NOT REPRESENTED
Jackson	NOT REPRESENTED
Jefferson	Lee A. Forestiere
	David C. Jacks
	Anna T. Ridling
Johnson	NOT REPRESENTED
Lafayette	NOT REPRESENTED
Lawrence	Ralph F. Joseph
Lee	NOT REPRESENTED
Little River	NOT REPRESENTED
Logan	Sanford E. Hutson, III
Lonoke	NOT REPRESENTED
Miller	John A. Gillean
Mississippi	Eldon Fairley
Monroe	Neylon C. David
Nevada	NOT REPRESENTED
Ouachita	NOT REPRESENTED
Phillips	Robert D. Miller, Jr.
Polk	John Finck
Pope	James G. Burgess
	Nathan Austin
Pulaski	Carlos A. Araoz
	Glen F. Baker
	Raymond V. Biondo
	Warren C. Boop, Jr.
	Kelsy J. Caplinger, III
	Gilbert O. Dean
	Fred O. Henker, III
	David Harshfield
Randolph	NOT REPRESENTED
Saline	Marvin N. Kirk, Jr.
Sebastian	Samuel A. Koenig, III
	John Lange
	William Schemel
	John D. Wells
	Paul I. Wills
Sevier	NOT REPRESENTED
St. Francis	NOT REPRESENTED
Tri-County	Michael N. Moody
Union	Willis M. Stevens, Jr.
	Gary Bevill
Van Buren	John A. Hall
Washington	William B. Nowlin
	David L. Rogers
White	NOT REPRESENTED

Woodruff	NOT REPRESENTED
Yell	NOT REPRESENTED
Resident Physician Section	NOT REPRESENTED
Medical Student Section	Cindy Gierach

Past Presidents

A. E. Andrews, John P. Burge, Asa A. Crow, C. Randolph Ellis, Ross E. Fowler, Albert S. Koenig, Jr; W. Payton Kolb, Kemal E. Kutait, T. E. Townsend, Robert C. Watson, and Charles F. Wilkins, Jr.

Others attending were: David Busby, Deborah Bryant, Peggy Cryer, William Dedman, Henry V. Kirby, Robert Kuykendall, Ken LaMastus, Rhys Williams, David Wroten, and Lynn Zeno.

Vice Speaker Gardner recognized Nominating Committee Chairman, Charles Logan and asked him to come forward to present the 1989-90 slate of officers.

Dr. Logan read the following slate of officers: President-elect, William N. Jones, Little Rock; T. E. Townsend, Pine Bluff; First Vice President, Michael Moody, Salem; Second Vice President, Brenda N. Powell, Hot Springs; Third Vice President, Joe H. Stallings, Jonesboro; Treasurer, James M. Kolb, Russellville; Secretary, Charles H. Rodgers, Little Rock; Speaker of the House, John Crenshaw, Pine Bluff; Vice Speaker of the House, Kelsy Caplinger; Delegate to the AMA, W. Payton Kolb, Little Rock; and Alternate Delegate to the AMA, Asa A. Crow, Paragould.

T. E. Townsend asked to be recognized and to have his name removed from the slate. William Jones was elected President-elect by acclamation.

Ray Jouett and Charles Wilkins escorted Dr. Jones to the podium to give the following address:

"I want to thank the Society for this great honor and privilege and yet awesome responsibility. I promise to serve you to the best of my ability and hope I deserve the confidence you have expressed by making me your new president-elect.

My only regret is that my mother and father are not here today but I know that they know. I'd like to thank lots of people who helped this election to take place. I want to thank my wife Ruthie and my four children for all their support and encouragement. I will do the very best I can. Thank you very much."

Nominations for other positions as proposed by the Nominating Committee were also elected by acclamation.

Vice Speaker Gardner turned the gavel over to newly-elected speaker, John Crenshaw of Pine Bluff.

Speaker Crenshaw asked A. E. Andrews of Texarkana to come forward and introduce our AMA guest speaker, Daniel P. Johnson, of New Orleans, Louisiana, Vice Speaker of the House of Delegates. Dr. Johnson's speech is printed elsewhere in this issue of the *Journal*.

Speaker Crenshaw thanked Dr. Johnson for his remarks and then asked Reference Committee #1 Chairman, George Roberson, Pine Bluff, to come forward to present his committee's report.

Report of Reference Committee Number One

George Roberson, Jr., M.D.

Mr. Speaker and members of the House of Delegates: Your Reference Committee Number One was composed of: Drs. Jim Magie of Conway, Joe Stallings of Jonesboro, Paul Wills of Fort Smith, and George Roberson of Pine Bluff, Chairman.

Your Reference Committee gave careful consideration to the following items and requests that the first four items be considered separately:

1. Resolution from the Young Physicians Committee concerning Medicaid/Medicare Reimbursement to Rural Hospitals.

   The Reference Committee reviewed the report and listened to the comments of the Young Physicians Committee and other participants. It was pointed out that several other organizations on the national level are addressing the problem of reimbursement discrepancy between rural and urban hospitals. It was recommended that the Arkansas Medical Society be supportive of those efforts through its legislative committee.

   Therefore the Reference Committee recommends amending the resolve to read: "The AMS goes on record supporting national and regional efforts to resolve reimbursement inequities between rural and urban hospitals."

2. Resolution from the Young Physicians Committee concerning the AMA Natural Science Ambassador Program.

   Your Reference Committee reviewed the report and listened to discussion from participants. The Committee noted that the Arkansas Medical Society does support a speakers bureau to enlighten the public regarding the science of medicine. It was recommended, and the young physicians were agreeable, to work to enlarge this program to involve appropriate science programs for schools which would encourage students into biological sciences. It is also recommended that the Arkansas Medical Society inform the schools of the availability of such programs. The Reference Committee recommends passage of the resolution.

3. Resolution from the Young Physicians Committee Concerning Tort Reform in Arkansas.

   The Reference Committee reviewed the resolution and listened to discussion from participants. Conceptually, a no-fault program is appealing to the medical profession. Political realities of accomplishing such a system through the Arkansas legislature appears bleak.

   The Reference Committee feels that the Arkansas Medical Society should have input from the young physicians on the

Governmental Affairs Committee in regard to work going on in this area with the Georgetown University Project and information from states where it is being actively pursued.

The Reference Committee recommends a do not pass of this resolution.

4. Resolution from the Young Physicians Committee Concerning a Physician-Owned Insurance Company in Arkansas.

   The Reference Committee reviewed the resolution and heard comments from insurance company representatives and participants. It is recognized by the Committee that there are now several options for insurance available in the state, with seven companies offering limited or extensive coverage. It is noted that St. Paul has stated an intent to reduce rates by 14% nationwide. The Arkansas Medical Society has investigated the possibility of a physician-owned insurance company in the past, and it has not been financially feasible. The Committee was concerned with the exorbitant charges on tail policies. Many of the young and new physicians commented that they had no knowledge of claims-made or occurrence type policies, or what a tail on a malpractice insurance policy involved. The Committee felt that educational pamphlets from the Arkansas Medical Society to new physicians on insurance, legal and business matters would go a long way in resolving this problem. The Committee recommended a do not pass for this resolution in view of the present insurance climate.

Mr. Speaker, this Reference Committee recommends that the following reports printed in the March, 1989 issue of the *Journal of the Arkansas Medical Society* be received for information since they require no action:

5. Report of the Committee on Aging, chaired by Dr. Ross E. Fowler.
6. Report of the Committee on Continuing Medical Education, chaired by Dr. Walter O'Neal.
7. Report of the Executive Vice President, by Ken LaMastus, CAE.
8. Report of the Committee on Hospitals, chaired by Dr. G. Max Thorn.
9. Report of the Trustees of the Pension Plan, chaired by Dr. Glen F. Baker.
10. Report of the Physicians' Health Committee, chaired by Dr. Joe L. Martindale.
11. Report of the Physician-Nurse Joint Practice Committee, chaired by Dr. Charles F. Wilkins.
12. Report of the Professional Relations Committee for the First Councilor District, chaired by Dr. Bascom P. Raney.
13. Report of the Professional Relations Committee for the Second Councilor District, chaired by Clarence W. Jackson.
14. Report of the Professional Relations Committee for the Sixth Councilor District, chaired by Dr. Herbert B. Wren.
15. Report of the Professional Relations Committee for the Seventh Councilor District, chaired by Dr. Bruce A. White.
16. Report of the Professional Relations Committee for the Ninth Councilor District, chaired by Charles A. Ledbetter.
17. Report of the Professional Relations Committee for the Tenth Councilor District, chaired by Dr. Samuel E. Landrum.
18. Report of Cleburne County Medical Society, Dr. Amador C. Campos, President.
19. Report of the Crittenden County Medical Society, by Dr. Steve P. Schoettle.
20. Report of the Sebastian County Medical Society, by Dr. Charles Floyd, President.
21. Report of the White County Medical Society, by Dr. Larry W. Weathers, President.
22. Report of the Arkansas Department of Health, by Dr. M. Joycelyn Elders, Director.
23. Report of the University of Arkansas for Medical Sciences, by Dr. I. Dodd Wilson, Dean.

Mr. Speaker, the Reference Committee recommends these reports be accepted for information.

Charles Wilkins made the motion that the Physician-Nurse Joint Committee chaired by himself be abolished because of its lack of workability. The motion passed unanimously.

Mr. Speaker, this concludes the report of your Reference Committee Number One. I wish to thank those who appeared before the Committee, members of the Committee, and those staff members who assisted us.

Mr. Speaker, I move the adoption of this report.

Upon a motion from the floor, this report was adopted. Speaker Crenshaw thanked Dr. Roberson and his committee for their work and then asked Dr. James Armstrong, Ashdown, and his committee to come forward and present the report from Reference Committee #2.

Report of Reference Committee Number Two

James D. Armstrong, M.D., Chairman

Mr. Speaker and members of the House of Delegates: Your Reference Committee Number Two was composed of Drs. Robert L. Baker, Mountain Home; Merrill J. Osborne, Blytheville; Robert R. Sykes, Nashville; and James D. Armstrong, Ashdown, Chairman.

1. Mr. Speaker, this Reference Committee recommends that the following reports printed in the March 1989 issue of the *Journal of the Arkansas Medical Society* be received for information since they require no action:
   a. Annual Session Committee, Dr. Glen Baker, Chairman
   b. Committee on Constitution and Bylaws, Dr. A. S. Koenig, Chairman
   c. Committee on Insurance, Dr. Eugene F. Still, Chairman
   d. Arkansas Medical Society Political Action Committee, Dr. John Crenshaw, Chairman





Above, left: Daniel Johnson, M.D., AMA representative, spoke to the House of Delegates on Saturday, Dr. Johnson is from New Oreleans and is the Vice Speaker of the AMA House of Delegates

Above, right: Dr. David Rogers presents the recommendations of Reference Committee #3 concerning the Report of the Long Range Planning Committee. Dr. Rogers is from Fayetteville and was the chairman of the reference committee.

Right: There was much discussion and lively debate on the reports and recommendations during the second House of Delegates.

Below: Dr. William Jones of Little Rock makes his acceptance speech upon his election at the President-elect for 1989-90 while newly-elected Speaker of the House, John Crenshaw and Nominations Committee Chairman, Charles Logan, look on.





e. Eighth Councilor District, Dr. William Jones, Councilor
f. Ninth Councilor District, Dr. Robert Langston, Councilor
g. Tenth Councilor District, Dr. Morton Wilson, Councilor
h. AMS Medical Student Section, Mr. Ron McGaugh, President
i. Medical Education Foundation for Arkansas (MEFFA), Dr. Martin Eisele, President
j. Tri-County Medical Society, Dr. Lewis Allen, Secretary
k. Arkansas State Medical Board, Dr. Joe Verser, Secretary

Mr. Speaker, this Reference Committee recommends these reports be accepted for information.

2. This Reference Committee reviewed and discussed the following reports which were printed in the March issue of the *Journal of the Arkansas Medical Society*:
   a. Budget Committee, Dr. Warren Douglas, Chairman
   b. Report of the Council, Dr. Larry Lawson, Chairman
   c. Indigent Care Committee, Dr. Asa Crow, Chairman
   d. Committee on Position Papers, Dr. James Kolb, Chairman
   e. Public Health Committee, Dr. Don Howard, Chairman
   f. Young Physicians' Committee, Dr. David Rogers, Chairman

   Mr. Speaker, this Reference Committee recommends these reports be accepted for information.
3. Fifth Councilor District Report.

   This Reference Committee recommends that the Fifth Councilor District report be accepted for information and recommends that the Arkansas Medical Society invite Dr. Joycelyn Elders, Director of the Arkansas Department of Health, to speak to the membership.
4. Resolution from the Young Physicians' Committee Concerning Payment of Arkansas Medical Society Dues.

   The resolution from the Young Physicians' Committee concerning payment of Arkansas Medical Society dues has some merit. This Reference Committee recommends that it be referred to the Council for further study and evaluation.
5. Resolution from Pulaski County Medical Society Concerning Third Party Payors.

   This Reference Committee strongly endorses Pulaski County Medical Society's resolution concerning third party payors and recommends its adoption.
6. Nominating Committee Supplemental Report

   This Reference Committee recommends the Nominating Committee Supplemental Report be referred to the Long Range Planning Committee.
7. PRO Liaison Committee Report

   This Reference Committee recommends that the PRO Liaison Committee report be accepted for information and that it be forwarded to the Board of Directors and to the membership of the Arkansas Foundation for Medical Care.
8. Committee on AIDS Report

   This Reference Committee has reviewed the report on the Committee on AIDS and recommends its acceptance for information.
9. Pulaski County Resolution Regarding the Medical Society of the State of New York's Resolution Concerning AIDS

   This Reference Committee reviewed the Pulaski County resolution which endorses the Medical Society of the State of New York resolution to be presented to the annual meeting of the American Medical Association in June, with regard to AIDS being designated as a communicable/sexually transmitssable disease. This Committee recommends adoption of the Pulaski County resolution and requests the Society to instruct our AMA representatives to support the New York resolution at the AMA annual meeting. This Committee likewise requests copies of this resolution to be submitted to the Arkansas State Board of Health, the Medical Society of the State of New York, and the American Medical Association House of Delegates.

Mr. Speaker, this concludes the report of Reference Committee #2.

I wish to thank those who appeared before the committee, members of the committee, and those staff members who assisted us.

Mr. Speaker, I move the adoption of this report.

Upon a motion from the floor, this report was adopted. Speaker Crenshaw thanked Dr. Armstrong and his committee for their hard work and asked for Reference Committee #3 Chairman David Rogers, Fayetteville, and his committee to come forward to present their report.

REPORT OF REFERENCE COMMITTEE NUMBER THREE

David L. Rogers, M.D., Chairman

Mr. Speaker, and Members of the House of Delegates: Your Reference Committee Number Three was composed of David Rogers, Chairman, Fayetteville; Brenda Powell, Hot Springs; William N. Jones, Little Rock; and James English, Little Rock.

Reference Committee Number Three was assigned to consider the Report of the Long Range Planning Committee, Dr. Lloyd Langston, Chairman, and we commend and congratulate Dr. Langston and his committee for the tremendous time and effort required to produce this document.

Your Reference Committee asks the members of the House of Delegates to consider this document as both a list of recommendations for topics of future discussion, as well as several specific recommendations which, if approved, will become immediate Arkansas Medical Society policy. We also ask the members of the House of Delegates to realize that many of these proposals will require changes in the Arkansas Medical Society Constitution and Bylaws before they can be implemented.

Those appearing before this committee expressed concern about two items in this report and we report on these areas first.

1. Goal #1, Section C

   Under Goal #1, Section C, most of those testifying felt that while alternative dues payment methods may be worth investigating, the two specific options mentioned could adversely affect Arkansas Medical Society income due to finance charges and loss of interest income. Therefore, your Reference Committee recommends that Section C be amended to read, "develop alternative dues payment methods."

   Mr. Speaker, Reference Committee Number Three recommends that Goal #1, Section C, be incorporated into the Report of the Long Range Planning Committee as amended.

2. Goal #4, Section A, Paragraph 2

   Under Goal #4, Section A, Paragraph 2, discussion concerned the demographics of the makeup of the proposed Governmental Affairs Council (GAC). Two issues which were addressed received favorable testimony.

   First, it was felt that the Arkansas Medical Society was accustomed to the councilor district as a working area in the state and that this distribution of committee members would work better than would a congressional district base.

   Second, it was recognized that the Arkansas Medical Society Auxiliary was under-represented on the GAC. Several who gave testimony felt that the Auxiliary members worked harder than any other group for the Governmental Affairs Department and that they should have more input into the function of that department.

   Mr. Speaker, Reference Committee Number Three recommends that Goal #4, Section A, Paragraph 2, be accepted for information and recommend it be referred to the Long Range Planning Committee for further study.

There was one other area of discussion that your Reference Committee felt should be addressed. It was requested that Goal #4, Section D, Paragraph 2, specify a sunset provision for "all *non-functioning* committees." We felt this was redundant and did not feel a change was needed.

Mr. Speaker, after careful consideration of testimony concerning all other aspects of this report, your Reference Committee feels this document, as amended, is worthy of pride, and should enable the AMS to better serve its membership.

Mr. Speaker, Reference Committee Number Three recommends the Report of the Long Range Planning Committee, as amended, be adopted and be referred to the Council for implementation.

Mr. Speaker, this concludes the report of the your Reference Committee Number Three. I wish to thank those who appeared before this reference committee, my fellow members of the committee, and those members of the staff who assisted us.

Upon a motion from the floor this report was adopted.

[Although the report of Reference Committee #3 is published as one report, there was a recess midway to allow for the memorial service to begin allowing family members who had traveled long distances to return home. (A list of those honored is published following this report.)] The House resumed and Reference Committee #3 continued to finish their report.

Speaker Crenshaw asked Chairman of the Council Larry Lawson, to give his Report of the Council which meets daily during the meeting. The report is as follows:

Report of the Council

J. Larry Lawson, Chairman

The Council met on Thursday, April 27, 1989, and conducted the following business:

1. Reviewed the 1988 Audit Report of the Arkansas Medical Society as prepared by Ferguson, Cobb, and Associates, CPA.
2. Voted to approve the Budget and Membership reports.
3. Voted to approve the dues exempt status of members submitted who are eligible for life, emeritus, and affiliate membership.
4. Voted to accept the offer from St. Paul Insurance Company to receive unclaimed dividends by physicians as a donation to the Physicians' Health Committee.
5. Heard an updated report from Dr. William Jones, Chairman of the Committee on AIDS.

The Council met on Friday, April 28, 1989, and conducted the following business:

1. Heard a report from Teresa Crisco who is with the Arkansas Society of Medical Assistants, asking physicians to encourage their office staff to join their association.
2. Due to a date conflict with the American Academy of Family Physicians, the Council approved moving the date and place of the 1990 annual convention from Little Rock to Hot Springs. The 1990 annual meeting will be at the Arlington Hotel May 2 - 6.
3. Appointed the following physicians to the Arkansas Medical Society Political Action Committee:
   Robert H. Langston, Harrison
   Joe H. Stallings, Jonesboro
   James L. Hagler, Little Rock
   Mrs. Kemal Kutait, Fort Smith
   W. Payton Kolb, Little Rock
   James H. Landers, Little Rock
   Mrs. Robert Gullett, Pine Bluff
   Hoy B. Speer, Jr., Stuttgart
   Charles P. Fitzgerald, Little Rock
   James M. Kolb, Jr., Russellville
   Charles H. Rodgers, Little Rock
4. Approved the appointment of W. Ray Jouett to the Medical Education Foundation for Arkansas (MEFFA).
5. Approved the appointment of the following physicians to the Young Physicians Committee:
   District 3: Robert A. Hayes, Wynne
   District 7: Bruce K. Burton, Malvern
   District 9: Larry Tuttle, Fayetteville
   District 10: Rick Harrison, Russellville

6. Approved the appointment of John R. Baker of Batesville and Forrest B. Miller, Jr., of Little Rock to the Physicians' Health Committee.

The Council met on Saturday, April 29, 1989, and transacted the following business:

1. Heard a report from Dr. Daniel Johnson, Vice Speaker of the AMA House of Delegate.
2. Appointed the following physicians to the Medical Services Review Committee:

   Gene France, Little Rock, representing Allergy
   Charles M. Davis, Pine Bluff, representing Dermatology
   Phillip Deer, III, Little Rock, representing Ophthalmology
   Carlton Chambers, Harrison, representing Otolaryngology
   H. Howard Cockrill, Jr., Little Rock, representing Radiology
   Charles D. Mabry, Pine Bluff, representing Surgery

3. Appointed the following physicians to the Subcommittee of Subspecialties of the Medical Services Review Committee:

   R. Lewis Crow, Little Rock, representing Thoracic Surgery
   Thomas J. Smith, Little Rock, representing Gastroenterology
   R. Cole Goodman, Fort Smith, representing Plastic Surgery
   John C. Schultz, Little Rock, representing Pulmonary Diseases
   Joseph W. Matthews, Little Rock, representing Pediatric Allergy
   G. Doyne Williams, Little Rock, representing Cardiovascular Surgery
   James A. Wellons, Little Rock, representing Nephrology
   Robert Anderson, DDS, Little Rock, representing Oral Surgery
   Eugene M. Shelby, Hot Springs, representing Emergency Medicine

4. Appointed Charles H. Rodgers of Little Rock to the Board of Trustees of the Arkansas Medical Society State Legislative Fund.
5. Appointed Tom Hollis of Hot Springs to the Arkansas Medical Society Pension Plan Board of Trustees.
6. Appointed the following physicians to the Position Papers Committee:

   Lloyd Langston, Pine Bluff
   Paul Cornell, Little Rock
   Jim English, Little Rock
   Lee Forestiere, Pine Bluff
   David Busby, Alma

7. Approved a motion to implement the Indigent Care Program in its entirety upon the approval of this report by the House of Delegates on April 29, 1989.
8. Voted to contribute $3,000 to the History of Medicine Library Associates to be used for recording a video history of medicine.

Dr. Lee Forestiere of Pine Bluff asked to be recognized to present a resolution honoring Senator Knox Nelson. Senator Nelson has been a long-time friend of medicine and and was undergoing open heart surgery. The motion passed unanimously. The resolution is printed below:

Resolution Honoring Senator Knox Nelson

Whereas, Senator Knox Nelson has undergone major surgery at the hands of our colleagues, and

Whereas, Senator Nelson is recognized as the leader of the Arkansas State Senate, and

Whereas, in his position as Chairman of the Public Health Committee, Senator Nelson has been ever mindful of the health care needs of Arkansans, and

Whereas, Senator Nelson has been a friend of medicine and conscious of the concerns of Arkansas physicians, now therefore be it

RESOLVED, that the Arkansas Medical Society, meeting this 29th day of April 1989, at our 113th Annual Session, remember Senator Nelson in our hearts and prayers, and wish his speedy and complete recovery.

Speaker Crenshaw announced that the Third Congressional District nomination for the Arkansas State Medical Board is Dr. Rhys Williams of Harrison. Dr. Williams is currently serving in this position, filling the unexpired term of Vernon Carter who resigned due to health reasons.

Speaker Crenshaw also announced that the Nominating Committee officers for the coming year are Charles Logan, Chairman and David Rogers, Secretary.

There being no further business the House was adjourned.

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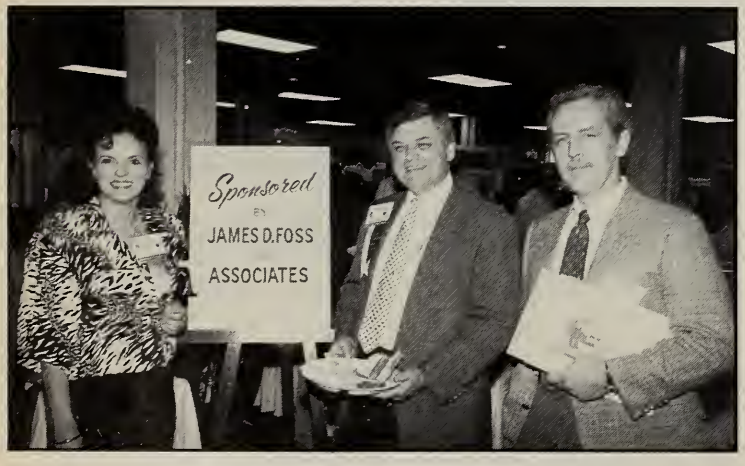




Exhibit Activities



John P. Burge, M.D., of Lake Village was the winner of the trip to the Bahamas.



Breaks and meals sponsored in the exhibit area were a big hit with the physicians.



Stuart N. Booth, of Booth Medical Equipment in Little Rock, accepts Dr. Hestir's congratulations for being the exhibitor grand prize winner of a weekend at the Peabody Hotel in Memphis.



The scientific booths were of great interest to the doctors.



L.J.P.Bell, of Helena, was the winner of a dinner for two. Dr. Sanford Hutson lent a hand during the drawings.

Address by Daniel P. Johnson, M.D.
New Orleans, Louisiana
American Medical Association
Vice Speaker of the House of Delegates

MEDICINE AT THE CROSSROADS

It is a distinct pleasure for me to come to Arkansas and represent the American Medical Association on the occasion of the 113th annual meeting of the Arkansas Medical Society. I would like to begin by paying tribute to the Arkansas delegation to the AMA, particularly delegates Allie Andrews, Tom Ed Townsend and Joe Verser. I understand that Joe will be stepping down at the end of the year after long and valuable service to the physicians of Arkansas in the AMA House of Delegates. We wish him well. I am told that Payton Kolb will be moving up to delegate to take Joe's place and we look forward to his participation in the House as a full delegate.

This is my first opportunity to spend any length of time in Arkansas and I am most appreciative for that chance. Coming as I do from your neighbor state to the south, I invite you to come to Louisiana and enjoy some of our hospitality.

Recently, I had another interesting and enjoyable experience, perhaps the single most important I have had as a physician. On that occasion I represented the American Medical Association as an observer at the first-ever leadership conference of the Canadian Medical Association. I had read and heard a lot about medicine in Canada and finally had the opportunity to see for myself. I emphasize that I wasn't there visiting hospitals or physician's offices. I was visiting with the leadership of the provencal medical associations and the Canadian Medical Association itself. I was startled to find out that with respect to the situation as it now exists in Canada, approximately 60% of the physicians with whom I spoke were in favor of the system of medical care delivery they have now. In light of what I had read, that discovery did not make a lot of sense to me. I began asking questions of those physicians in favor of this system and as they began to describe their system to me, I became even more disenchanted. Let me outline to you some of the things that I heard and I think you will understand where I am coming from.

One rather articulate physician who was very well qualified and well trained told me he was a proponent of the system. He explained to me that the Canadian system uses a significant portion of the beds in acute care hospitals (apparently about 30%) for long term care patients. It is my observation that this is one of the mechanisms used to ration the delivery of care. If part of the beds are filled with long-term patients, there is less room for acute-care patients who need admission and certainly less room for elective-care patients who desire admission. My new friend gave me an example of a patient who had experienced a seizure at home and was brought to the hospital and admitted to his service. She stayed in the hospital for a year although she never had another seizure in the entire time she was in the hospital.

This physician went on to explain to me that in his hospital (in Quebec) they have an ongoing problem adhering to their budget. For all intents and purposes, the budget is flat with little or no annual increase. Therefore in order to make ends meet, they close the hospitals down to acute-care admissions for approximately six weeks during the summer. However, that is still not sufficient to enable them to operate within their budget. Therefore, they close the hospital down again for approximately three weeks over Christmas and New Year's.

Apparently, what you and I read about delays in delivery of care is accurate. If one has chest pain, it may take four months before an angiogram can be obtained. If it is determined that the patient needs bypass surgery, it may take eight months to get the operation performed. Delays for corneal transplant are up to two years and hip replacement surgery one to two years. These delays are manifestations of rationing mechanisms that exist and exist for the purpose of holding down the cost of delivering the care.

Why would any physician stand for such a system? Let's examine that point for a moment. Some of the physicians don't get paid quite as much as you and I do for delivering the same services but they have done reasonably well over the time since this system was imposed. They don't have to bill anyone. The patient comes in and presents a card that looks like an American Express card. The physician's office person imprints a form with the card, writes down the services delivered and sends in the form. Payment comes within three weeks. There are no other insurance forms to fill out, no hassle to speak of, no collection procedures and no bad debt. To be sure, the government accumulates data on how many of what kinds of cases physicians are seeing and is in a position to clamp down on a physician it thinks is seeing too many patients of one kind or another. However, the interference with individual practice does not yet seem to be of the magnitude that already exists in this country. So on balance, they had a fairly good deal up to now. When you factor in that six weeks of vacation in the summer and three weeks vacation in the winter it's not so bad for the physicians. So who gets the short end of that stick? It is the patient who suffers. In this country if someone truly needs coronary bypass surgery, he or she needs it tomorrow, or

the system has saved a considerable sum of money.

It is only fair to point out that there are many Canadian physicians who are violently opposed to this system. On several occasions since my visit to Canada, in speaking before County Medical Societies, invariably one or more physicians will come up to me who have moved to the United States from Canada because of opposition to the system there. A significant number of the physicians remaining in Canada are strongly opposed to the system as it currently exists.

My purpose in discussing all of this is that there suddenly has developed in this country a special chemistry for change. I believe that this chemistry represents a threat to us as physicians and, more importantly, to our patients. One of the most interesting things that I learned in Canada was that when they first began their system, the reason that they proposed the system was that a significant part of their population had no medical insurance. At that time, the uninsured population represented about 11.5% of their total. In this country, at this time, 17.4% of those people under 65 have no insurance. Thus, we currently have in this country an uninsured population that is vastly larger than existed in Canada at the time of the inception of the system we have just discussed. Superimposed on that fact is the perception of the American people that the medical care in this country is too expensive. This public sentiment is aggravated in part by the fact that we do have some greedy brothers and sisters in medicine who make that proposition more credible by gouging their patients. However few of those apples get into our barrel, they nevertheless taint the rest of us when it comes to the public's perception. How many people understand what it means to allocate 11.3 -11.5% of the GNP to health? However, the American public is constantly being brainwashed that this is too much, by the print and electronic media.

And then we look at big business like Chrysler. As you know, Lee Iacocca is no friend of ours and never has been. His advisor on health insurance matters is Joe Califano! Iacocca is happy to point out that $700.00 of the cost of every automobile that Chrysler produces can be related to the health care system. Many big businesses are self-insured. They spend huge sums of money for health coverage but it is first dollar coverage because big unions have cooperated with them to make sure that everything from cradle to grave is covered by the big companies. The unions won't stand for patient accountability. So suddenly, these big companies see a way to retreat from their expenditures by going to the Canadian system. All of this activity has built up a sense of need in the minds of the public and an interest in alternatives to the current system. And the media are all happy to present the alternative in concert with those politicians, and even some physicians who have suggested that the Canadian model is the one that will lead us all out of this difficulty we have and into the promised land. They advocate this without regard to what is actually going on north of the border and whether it will in fact offer any improvement.

Perhaps I should digress. I want to point out to you that those physicians in Canada who have been seduced into thinking that this is a good arrangement for them are on the verge of a very rude awakening because of several things are happening in Canada that will be bad for physicians just like they have been bad for the patients. First of all, in spite of all those rationing mechanisms that are currently in place, the policy makers now feel they are going to have to take more out of the physicians' pocket. Up till now, the physicians have been able to see as many patients as they want and to bill for as many services as they provided. Now mechanisms called by other names that are very much like expenditure targets advocated by the Physicians Payment Review Commission are being put into place. Thus, if a physician sees too many patients, at the end of the quarter or the end of the year, depending upon the provencal system, he will have to give money back to the government. So, that physician is being told, "Don't deliver the care, Doctor. If you do, and you deliver too much care, you will have to pay us back for the excess." Some Canadian provinces are not content with this and are going a step further. They have decided to impose the HMO model that you and I have come to love in this country upon the Canadians. Bear in mind that we are not talking about a voluntary situation in which the person is buying the HMO coverage such as a person may do in this country. Instead the patient will be forced, along with the physician, into this managed care system. This gives the province the opportunity to totally control the physicians, leaving physician and patient no voice at all.

As if this potential for rapid change weren't bad enough, there has been a recent Harris Poll in this country with respect to the Canadian system and I would like to read you the question asked. "In the Canadian system of national health insurance, the government pays most of the cost of health care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals. Under the Canadian system, people can choose their own doctors and hospitals. On balance, would you prefer the Canadian system or the system we have here?" This was a part of a telephone poll with no opportunity for explanation. I submit that what the listener would hear in such a situations is, "Here is a system in which we can control what the doctor or hospital charges you and you don't have to pay a cent." I personally think it is a miracle that only 61% of Americans favored the Canadian system over our system, given the type of proposal in the poll. However, the final nail, or potential nail, in our coffin can be found in this prejudicial poll. Proponents of a switch to the Canadian system can now allege that there is clear documented evidence that the American people would prefer to go to this new system and trash our current system.

Admittedly, it all seems pretty bleak. But I would like to suggest to you that this chemistry of change can be viewed as a chemistry of opportunity. There are two kinds of opportunity. All of a sudden we are given a narrow window of opportunity to do something. But we must decide whether we are going to approach the threat of imposition of this system on our patients by going our separate ways, cutting special deals with the government specialty by specialty or whether we are going to approach this window of opportunity collectively.

In making that choice, I submit we are off to a bad start. My

own specialty of radiology cut a deal with Representative Stark, Chairman of the Subcommittee on Health of the House Energy and Commerce Committee, accepting MAACs in return for a prohibition of DRGs for radiologists. I personally think the separate deal was a bad one. But is it any worse than what the surgeons have done? The American College of Surgeons has suggested to the Congress that mandatory assignment would be hard for surgeons but would be all right for those physicians who work in the hospital setting where the patient makes no specific choice. They were thinking about the emergency room physician. If you are an emergency room physician, you might not be too thrilled about the American College of Surgeons' plans for you. But there are other people who function in a typical American Hospital in a system designed by you and me in which the patients don't necessarily have a specific choice. I refer to my own specialty of radiology as well as anesthesiology, pathology, and cardiology. The American College of Surgeons says mandatory assignment is all right for those groups. Cut them out of the herd. Divide us up!

The American College of Surgeons has further stated that they would accept expenditure targets as long as the targets are set up at the appropriate levels. It is difficult to imagine a scenario in which in return for agreement to set the targets at appropriate levels, the targets are instituted and then ratcheted down? A spokesman for the American Academy of Family Physicians has said that they would accept mandatory assignment as long as the fee schedule was up at an appropriately high level. Doesn't that sound like Canada revisited? In truth, what happened in Canada was that they started out with a fee schedule that wasn't so bad. Once everything was in place, the government began to tighten the screws.

As that old cliche goes, "I'm from the Federal government and I am here to help you! Sit down with me and we're going to make this fantastic deal." You sit back and ultimately it's the patient who is going to be the one who suffers.

On the other hand, there is a way to approach this crossroads and turn it into something positive for your patients. We have the mechanism to develop policies that are pro-active, that speaks to the weaknesses in our system and preserve the strengths. Some of this will take a hard sell and it will require that you and I and all our colleagues work together, individually and collectively.

For example, the Medicare program is about to go bankrupt. It is in terrible financial status as you and I know. Add to that situation the fact that next year there will be four workers for every beneficiary but by the year 2025 there will be two workers for every beneficiary. The number of people over 65 will double over the next 50 years and the number of people over 85 will triple. As bad as it is right now, it's only going to get worse. What the AMA advises is a restructure of Medicare to put it on an actuarially sound basis and make it into a program that takes care of not only the liability of the people who are working now and are going to be beneficiaries at some later time, but the people who are elderly at this time. Most assuredly, it will involve some increase in taxes. Lee Iacocca says that if you talk about raising taxes in Washington right now it's like quoting Satanic Verses to the Ayatolla. Nevertheless, we in organized medicine are out front on this issue and we need to work hard to make sure that we are heard.

The Medicaid program is in shambles; 60% of the people who are below the poverty line are not served by the program. Then we add the dilemma of the uninsured who won't be helped by the revision of these two programs and we have to address that. You and I have to look at the concept of requiring even employers of small numbers of people to provide some kind of basic level of insurance.

These dilemmas are realities and we have to deal with them, developing programs that will provide solutions. However, all of the solutions involve some kind of patient accountability and none is more important than the program to deal with the elderly which was adopted in Dallas at the Interim meeting of the AMA House of Delegates in December of 1988, the so-called Report AA. This report says there ought to be an indemnity schedule of benefits. There ought to be a logical way of allocating the third parties' resources, whether it is the federal government or some individual insurer. There should be a preservation of the right of each individual physician and patient to deal with the difference between the amount charged and the amount the payment schedule will pay. And finally, as you have done in Arkansas, we should have some type of voluntary assignment program to take care of those people who simply do not have the means to pay for the difference.

You and I demonstrated our ability to interact one on one with patients because 78% of the Medicare claims in this country are taken on assignment. So we have the policy. I submit that we can take the Canadian threat and use it to our best advantage to explain to the public the need for some patient accountability. Up until now, we have had no good mechanism for explaining to our patients why they should become involved. We should seize the moment to shine a light on the Canadian system; to turn up the wattage so that our patients can see it as well as they can and understand what is at stake for the patients of this country. Instead of running off to cut separate deals with representatives Stark and Waxman, you and I should work together to see to it that the specialty societies understand that there is a forum called the AMA House of Delegates which provides an opportunity twice a year for all of us to come together and decide what is best for our profession and our patients.

Hammer it out! Fight it out! Advocate! Try and talk the other fellow into your position. But when it is all done, walk out of that door together instead of running out the back door to Rep. Stark and try to cut a special deal with him. The sudden focus on the Canadian system presents us with a major opportunity. Let's not let it slip away.

To close, I would like to share with you some personal comments about being a physician. As bad as it is right now and in spite of so many things which are happening, I don't think there's ever been a more wonderful opportunity to serve as a physician than there is now in this country. I am happy to report to you that the decline in applicants to medical school

has leveled off and I hope that a real increase in applications will take place. A couple of years ago I heard a humorist named Bill Copeland from St. Louis speak at a meeting of the Physician Insurers Association of America. At the end of a very entertaining talk, he closed with some serious thought. One of the things that he said was, "How can you be burned out, if you never been lit?" I suggest that you leaders of medicine in this great state have an opportunity to energize your colleagues. And I hope that you feel as I do that when a patient walks into your office or mine that patient extends to you a special trust just by walking through that door. That trust represents both an opportunity and a responsibility. There are very few segments of our American society that enjoy such a privilege. Isn't that worth working for? I submit to you that it makes no sense at all for you and me to have worked so hard in the past for our profession and then just hand it over to other people who have some agenda that is not in the best interest of our patients.

How can you burn out, if you've never been lit? Thank you.

Memorial Service

The names of those honored at the memorial service, Saturday, April 29 are:

Society Members

Frank M. Adams, Hot Springs
Raymond C. Cook, Little Rock
Louis A. Draeger, Danville
Gwilym A. Edwards, Hot Springs Village
John Q. Elliott, Blytheville
L. Murphey Henry, Fayetteville
Ernest J. Hermann, Jr., Abilene, Texas
Bryant W. Jones, Paragould
Sanford C. Monroe, Pine Bluff
James M. Nisbett, Little Rock
Johnnie C. Price, Jr., Monticello
Charles W. Rasco, Jr., DeWitt
E. Frank Reed, Jr., Pine Bluff
Paul L. Rogers, Charleston
John A. Teeter, Little Rock
A. James Thompson, Little Rock
Robert M. Tirman, Little Rock

Auxiliary Members

Mrs. Thomas H. Allen, Little Rock
Mrs. Stephen Graves, Fort Smith
Mrs. Howard Harris, Dumas
Mrs. Frank L. Irby, El Dorado
Mrs. J. W. Jacks, Hiwassee
Mrs. Bryant W. Jones, Paragould
Mrs. C. W. Jones, Benton
Mrs. Henry E. Mobley, Morrilton
Mrs. Joseph F. Shuffield, Little Rock
Mrs. A. G. Sullenberger, Pine Bluff

Spouses of Members

Mr. Jack Diner, Little Rock, spouse of Dr. Wilma C. Diner
Donna Graves, M.D., Fort Smith, spouse of Dr. Stephen C. Graves
Mrs. William A. Hudson, Harrison
Mrs. Buford M. Gardner, Fayetteville
Mrs. Albert R. Sparks, Crossville, TN

Exhibitors

The Arkansas Medical Society wishes to thank the following exhibitors and sponsors for their help during the 1989 annual meeting. Their support made the 1989 meeting our best ever!

Scientific Exhibitors

"Pelvic Masses: Is Ultrasound Still Number One?", sponsored by Teresita L. Angtuaco, M.D.; Hemendra R. Shah, M.D.; Rite L. Micthell, B.S.R.T., R.D.M.S.; and David Kinder, R.T.

"Perioperative Nutritional Evaluation of Orthopaedic Patients", sponsored by Fred Nusbickel, M.D.; Carl L. Nelson, M.D.; and Charyl Puskarich, Ph.D.

"Pain Management", sponsored by Robert F. Finnegan, M.D.; David Huggins, M.D.; and Dan Robertson, M.D.

"Copper Vapour Lasers", Milton Waner, M.D.; J. Michael Key, M.D.; and James Y. Suen, M.D.

"A New Mechanism of Human Accommodation", sponsored by R. Sloan Wilson, M.D.

"Innovations in Orthopaedics", sponsored by John G. Slater, Jr., M.D.; Berry Thompson, M.D.; Robert Porter, Jr., M.D.; and Charles Pearce, Jr., M.D.

"Use of Transcranial Doppler in Neurosurgery", sponsored by Stevenson Flanigan, M.D.; William M. Chadduck, M.D.; and James R. Adametz, M.D.

"In Vitro Fertilization at the University Hospital of Arkansas", sponsored by Steven London, M.D. and Glenn Weitzman, M.D.

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Arkansas MADD
Arkansas Orthopedic Appliances, Inc.
Baylor University Medical Center Transplantation
Bio-Tech Pharmacal, Inc.
Booth Medical Equipment Company
Brentwood Instruments, Inc.
Burrough Wellcome Company
Cardiac Analysis Center
Centers for Youths and Families
CNA Insurance Companies

Data Reducation Services
Diabetes Treatment Center
Dodson Insruance Group
Donoho & Merry Insurance, Inc.
Eli Lilly and Company
First Choice, Inc.
James D. Foss & Associates
Glaxo Pharmaceuticals
Health Care Management Services
International Medical Electronics, Ltd.
J's Homecare Medical Services, Inc.
Jansen Pharamceutica
Knoll Pharmaceuticals
Latham and Hutchinson, Inc.
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Prize Winners

Robert Baker, M.D., of Mountain Home, won our drawing for three free night's accommodations at the Arlington for being the first person to register for the annual meeting.

John P. Burge, Lake Village, was the grand prize winner of trip to Bahamas Princess Resort and Casino, Grand Bahama Island. The trip was donated by **Tours and Travel of Russellville.**

The exhibitor grand prize winner of the Peabody weekend was Stuart N. Booth, of Booth Medical Equipment in Little Rock.

Other prize winners were:

L. J. P. Bell, Helena, dinner for two, donated by **Latham and Hutchinson, Inc.**

James Kolb, Russellville, golf putter, donated by **Merrell Dow.**

Nathan Auston, Russellville, cordless phone, donated by **Donoho & Merrry Insurance, Inc.**

Joe Stallings, Jonesboro, 7" portable television, donated by **Data Reduction Services.**

Donald Meacham, Little Rock, umbrella, donated by **Shearson Lehman Hutton.**

Registration Figures for 1989 Annual Session

Registered physicians - 242
Registered spouses - 124
Non-registered physicians (Saturday only) - 125
Exhibitors - 180

Attendance for Lectures

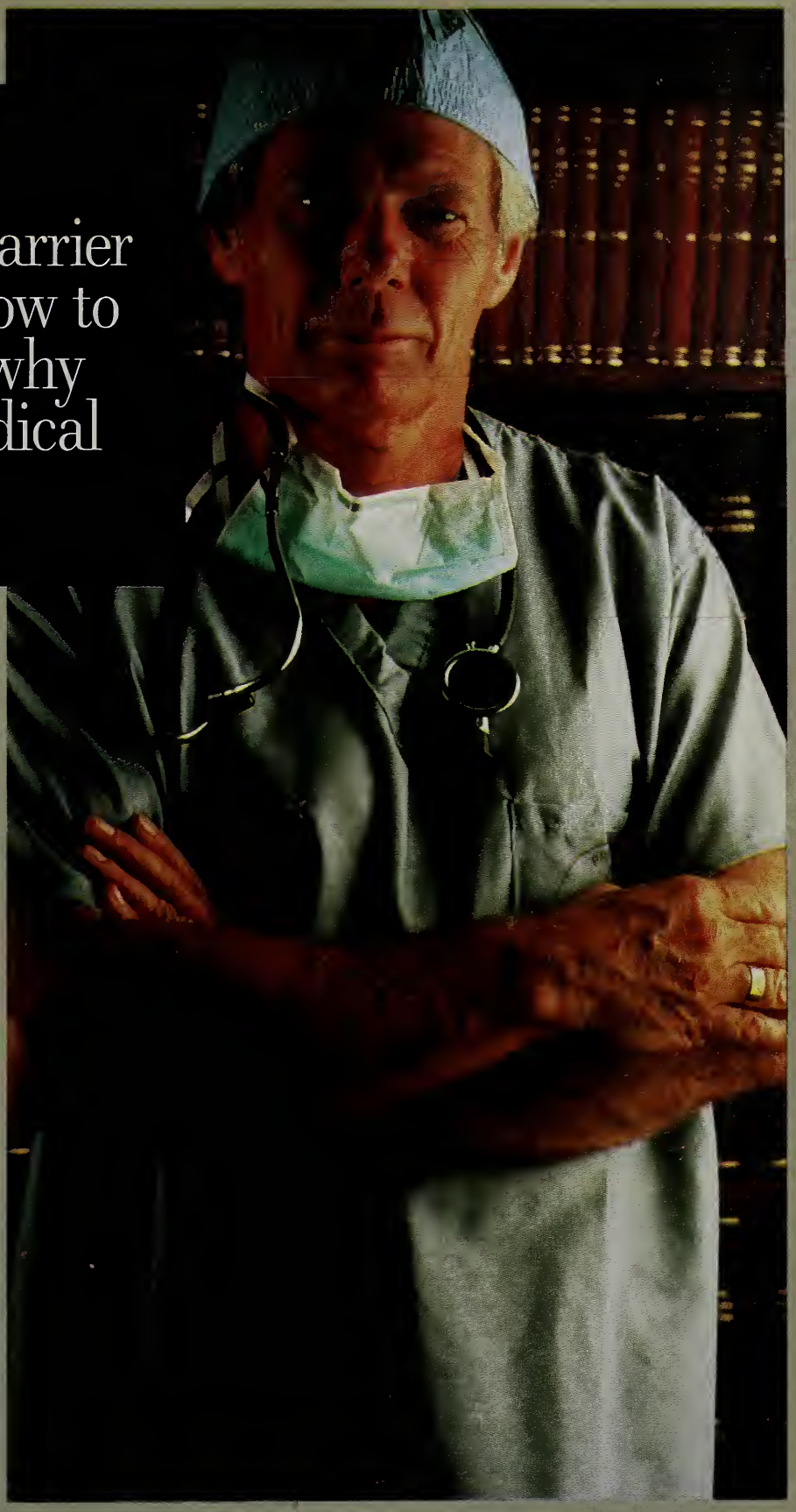
"The Massachusetts Universal Health Care Plan", William M. McDermott, Jr, M.D. - **111**

Shuffield Lecture, Peter Huber, J.D., Ph.D - **300**

"Are Practice Guidelines Cookbook Medicine?", Lucian Leape, M.D. - **100**

"Harvard Resource Based Relative Value Scale" - Paul Ginsberg, Ph.D. - **145**

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Lucian Leape, M.D., Harvard School of Public Health and Dr. Glen Baker, AMS Annual Session Committee Chairman, relax before Dr. Leape spoke about medical guidelines and regulations.



Peter Huber, J.D., Ph.D., spoke about the liability crisis which exists in medicine today. Dr. Huber was the lecturer during the Shuffield Luncheon.



Left: Paul Ginsburg, Ph.D., answers a question during his presentation about the Harvard Resource Based Relative Value Scale. Dr. Ginsburg is the Executive Director of the Physician Payment Review Commission which presented its recommendations on the HRBRVS to Congress.

Right: William Eldredge, a Little Rock attorney, receives the 1989 Shuffield Award from Dr. Hestir. The Shuffield Award is given each year to a lay person who has made a significant contribution of time and talent to medicine.





Right: It was standing room only for Dr. William McDermott's discussion about the Massachusetts Universal Health Care law. Dr. McDermott is the Executive Vice President of the medical society of Massachusetts.

Other Activities

The Massachusetts Universal Health Care Plan: Is it a National Trend?

"The Massachusetts Universal Health Care law is hanging by a fiscal thread...and may not be implemented at all." These were the words of the William M. McDermott, Jr., M.D., the Executive Vice President of the Massachusetts Medical Society.

In what began as a high profile issue for the Dukakis campaign to use against George Bush, the Universal Access Law (Chapter 23) has run into funding and administrative problems, according to Dr. McDermott.

In his presentation, Dr. McDermott explained that no one every really knew what the cost of universal health care would be and that estimates ranged from $500 million to $1 billion. The basic plan provided that all employees of more than five persons were required to provide private insurance coverage for their employees or pay $1,680 per employee to go toward the establishment of a state insurance fund. The coverage, however, also was to pay for the working disabled, pregnant women, disabled children and college students. According to McDermott, there simply wasn't enough money to go around.

Surveys of Massachusetts citizens revealed that the public was in favor of Universal Health Care, but they were unwilling to pay and adamant against new taxes to support the program.

Noting that the state of Massachusetts was $600 million short of meeting current general expenditures, Dr. McDermott, explained that the Dukakis administration had reneged on their promise to properly fund the Universal Health Care Pool. Dr. McDermott stated, "I believe that it's time for physicians to make universal health care a reality for all, but we simply do not have the commitment to make it work."

Shuffield Luncheon/Lecture

William A. Eldredge, Jr., a senior partner in the Little Rock-based Friday, Eldredge & Clark, Law Firm, was presentd the the 1989 Shuffield Award, Friday, April 28, during the annual Shuffield Luncheon and Lecture.

The award, presented by John M. Hestir, M.D., of DeWitt and Joseph, Norton, M.D., a close personal friend of Mr. Eldredge's, was given before an audience of over 300 physicians and guests. Dr. Norton nominated Mr. Eldredge for the award.

After the award ceremony, Peter Huber, J.D., Ph.D., presented his views on "Liability, the Revolution and Its Consequences." Dr. Huber has written a book by the same title and because his topic is a source of great concern to all physicians, his presentation was considered very relevant by the attendees.

Harvard Resource Based Relative Value Scale

A large crowd of over 150 persons turned out Saturday, April 29, to hear Paul Ginsburg, Ph.D., Executive Director of the Physician Payment Review Commission in Washington, D.C. The Physician Payment Review Commission report on the HRBRVS had just been presented to Congress on Thursday, April 27. The group was one of the largest to gather for an Arkansas Medical Society annual session program.

According to Dr. Ginsburg, the Commission found that the Harvard study, if modified in specific areas, could provide a sound basis for a Medicare fee schedule. The Commission is also recommending ways to address malpractice insurance costs, geographic differences, coding reforms and balance billing in any proposed fee schedule.

A complete summary of these and other speakers will be included in the July 1989 issue of the Journal. Watch for it!

Specialty Meeting Notes

Arkansas Psychiatric Society
Frederick G. Guggenheim, M.D., President

The scientific part of our meeting focused on the treatment of serious mental disorders. Jeffery Clothier, M.D., Assistant professor of Psychiatry from the University of Texas Medical School at Houston, spoke on the "Role of Anticonvulsants in the Treatment of Refractory Mania." Stefan Bracha, M.D., Associates Professor of Psychiatry and Neurology at UAMS lectured on the "Treatment of Refractory Psychosis" focusing both on low dosage neuroleptics, especially the use of decanoate monthly infections (fluphenazine or haloperidol) as well as on the role of Lithium Carbonate.

At the business meeting we unanimously endorsed the importance of having a psychiatric physicians on the Arkansas State Hospital Board. Up until 1989, there was almost always a psychiatrist on the board. His/her insights were useful in understanding the complexities of inpatient care and the increasing number of options linking community mental health

systems. Now more than ever, experienced oversight can benefit the Board's mission.

Arkansas Society of Plastic and Reconstructive Surgeons

E. F. Still, II, M.D., President

The Arkansas Society of Plastic and Reconstructive Surgeons met at 1:30 p.m. on Saturday, the 29th of April at Hot Springs in conjunction with the AMS meeting.

The focus of the meeting was a presentation of several cases by Dr. Luther Walley who practices plastic surgery in Hot Springs. Following this, plans were solidified for an educational program to be run by the Society and presented to both medical professionals and the lay public. Dr. Cole Goodman of Fort Smith was elected as the representative to the Medical Service Review Board and selected again as officers were: Dr. Still of Fort Smith as president; Dr. Vogel of Little Rock as vice-president; and Dr. Norton Pope of Little Rock as secretary-treasurer.

If you would like to have the notes from your specialty meetings included in the Journal, just send them to: Martha S. Taylor, Journal Managing Editor, Post Office Box 5776, Little Rock, AR 72215. We will be happy to include any information concerning your meetings.

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Jerry Morgan, Stuttgart	1991
James Bledsoe, Rogers	1991
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William Jones, Little Rock	1991
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Thomas H. Hollis, Hot Springs	1993

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** *Term begins September 1st.*

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10	James L. Maupin, Dardanelle	1990

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Charles H. Rodgers, Little Rock
Ex-Officio: AMS President

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5	William Dedman, Camden (FP)	1991
6	Jonathan Hoyt, DeQueen (IM)	1991
7	Bruce K. Burton, Malvern (IM)	1992
8	David L. Harshfield, North Little Rock (R)	1990
9	Larry D. Tuttle, Fayetteville (FP)	1992
10	Rick W. Harrison, Russellville (PD)	1992

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5	Raymond N. Bowman, El Dorado	1991
6	James D. Armstrong, Ashdown	1990
7	Brenda N. Powell, Hot Springs	1991
8	Charles W. Logan, Little Rock - Chairman	1990
9	David L. Rogers, Fayetteville - Secretary	1991
10	Frank M. Lawrence, Russellville	1990

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Jim E. Lytle, Batesville
Charles F. Wells, Morrilton

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Carl E. Northcutt, Stuttgart
Dwight W. Gray, Marianna

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* Howard R. Harris, Dumas
Vacant
George Roberson, Pine Bluff

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L. V. Ozment, Camden
John E. Alexander, Jr., Magnolia

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James G. Martindale, Hope
James D. Armstrong, Ashdown

District 7:
* Bruce A. White, Malvern
Vacant
Vacant

District 8:
* Charles H. Rodgers, Little Rock
Kelsy J. Caplinger, III, Little Rock
Curry B. Bradburn, Jr., Little Rock

District 9:
* Charles A. Ledbetter, Harrison
James Y. Massey, Mountain Home
James L. Pickens, Rogers

District 10:
* Samuel E. Landrum, Fort Smith
David M. Williams, Russellville
Boyce West, Clarksville

Medical Services Review Committee

Leslie F. Anderson, Lonoke (FP)	1990
Samuel A. McGuire, III, Forrest City (FP)	1991
Michael N. Moody, Salem (FP)	1991
Robert S. Gaston, Little Rock (IM)	1990
Frederick C. Turner, Mountain Home (IM)	1991
Paul M. Anderson, Fort Smith (GS)	1990
Charles D. Mabry, Pine Bluff (GS)	1992
John C. Jones, Little Rock (GS)	1991
Gene L. France, Little Rock (A)	1992
Robert G. Valentine, Jr., North Little Rock (AN)	1991
Charles M. Davis, Pine Bluff (D)	1992
Carlton Chambers, Harrison (OTO)	1992
Philip Deer, III, Little Rock (OPH)	1992
Stephen R. Marks, North Little Rock (OBG)	1990
W. Ray Jouett, Little Rock (NS)	1991
W. Payton Kolb, Little Rock (P)	1991
Susan A. Keathley, Little Rock (PD)	1990
H. Howard Cockrill, Jr., Little Rock (R)	1992
Mae B. Nettleship, Fayetteville (PTH)	1990
Stuart B. McConkie, Hot Springs (ORS)	1990
Charles Logan, Little Rock (U)	1991

Charles Rodgers, Little Rock (FP) - Chairman
John Crenshaw, Pine Bluff (IM) - Vice Chairman
Ex-officio: AMS Executive Committee

Medical Services Review Committee Subcommittee on Subspecialties

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Thomas J. Smith, Little Rock (GE)
R. Cole Goodman, Fort Smith (PS)
John C. Schultz, Little Rock (PUD)
Joseph W. Matthews, Little Rock (PDA)
G. Doyne Williams, Little Rock (CS)
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AIR FORCE



Arkansas Medical Society Auxiliary Convention Report, April 27 - 29, 1989



Mrs. J. Larry Lawson (Nikki)
President 1989-1990
Arkansas Medical Society Auxiliary

The pre-convention board meeting of the Arkansas Medical Society Auxiliary was held at 2:00 p.m. on Thursday, April 27, with President Sara Jouett presiding. Discussion and action was taken on issues to be presented to the House of Delegates.

On Thursday evening, the Medical Society and the Auxiliary jointly hosted a reception to honor all past presidents of the Medical Society and Auxiliary. A silent auction to raise funds for AMA-ERF was a highlight of the evening. Items for the auction were contributed from the county medical auxiliaries. All funds raised were given to AMA-ERF in honor of the past presidents.

On Friday, April 28, the 65th Annual Session of the Arkansas Medical Society Auxiliary was called to order at 9:00 a.m. by President Sara Jouett. Special guests were Dr. John Hestir, 1988-89 AMS President; Dr. James Weber, President-elect; Ken LaMastus, Executive Vice President; Peggy Cryer, Director of Administrative Services; Mrs. Barbara Thibodeaux, President, Southern Medical Association Auxiliary; and Mrs. Mary Lynn Smith, American Medical Association Auxiliary Legislative Committee Chairman. Mrs. Smith gave the keynote address, "Together, Focus on the Future and Legislation."

Reports were given by officers, committee chairmen and presidents of county auxiliaries. The 1989-90 budget was presented and approved. Resolutions were passed changing the Martha Harding Gann Memorial Fund and the Ilse F. Oates Student Loan Fund from loan to scholarship funds. Community projects efforts by several county medical auxiliaries were on display in the exhibit hall.

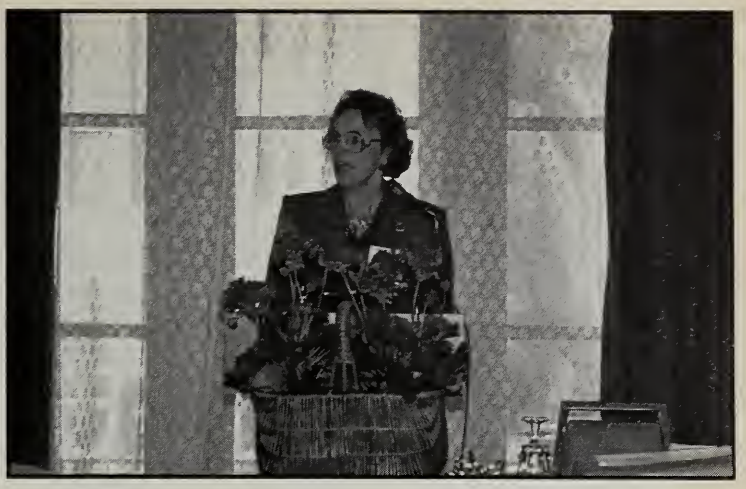
A new slate of officers was elected for 1989-90: Mrs. Larry Lawson (Nikki), President; Mrs. David Williams (JoAnn), President-elect; Mrs. Trent Pierce (Melissa), Recording Secretary; Mrs. Steve Schoettle (Sue), Treasurer; Mrs. Joe T. Wilson (Gail), N.E. Vice-President; Mrs. Charles Brown (Mickie), N.W. Vice-President; Mrs. Jerry Thomas (Evelyn), S. E. Vice President; and Mrs. Allen Lee (Cathy), S.W. Vice President.

A luncheon at the Belvedere Country Club finalized the 65th Annual Session. Awards were given to country medical auxiliaries for most membership increase; best Doctor's Day projects; funds raised for AMA-ERF; and best community project, (Vinnie E. Garrison Memorial Award). Newly elected officers were installed by National Representative, Mary Lynn Smith. President Nikki Lawson presented her president's message, stating her plans for the coming year.

The post-convention board meeting was held immediately after the luncheon.



Mrs. Joe Ed Smith, Chairman of the AMA Auxiliary Legislation Committee, discusses the role of the Auxiliary in medical legislative matters while Mrs. Sara Jouett listens attentively.



Mrs. Sara Jouett made her final address as President of the AMS Auxiliary at the Belevedere County Club in Hot Springs.



Mrs. Nikki Lawson received the gavel and the presidency of the Auxiliary from Mrs. Sara Jouett. Mrs. Lawson resides in Paragould.



New officers for 1989-90 are (left to right): Mrs. Gail Wilson, N.E. Vice President; Mrs. Evelyn Thomas, S.E. Vice President; Mrs. Mickie Brown, N.W. Vice President; Mrs. Sue Schoettle, Treasurer; Mrs. David Williams, President-elect; and Mrs. Nikki Lawson, President. Officers not shown are Mrs. Melissa Pierce, Recording Secretary and Mrs. Cathy Lee, S.W. Vice President.



The past presidents of the Auxiliary had their annual breakfast and a good time was had by all.



The Auxiliary had a great showing in the exhibit hall with three tables displaying the county and state projects of the past year.

THINGS TO COME

JUNE 24

Arkansas-Oklahoma Endoscopic Society 1989 Annual Meeting. Sponsored by AEOS. Presented by Walter J. Hogan, M.D., President, ASGE; Edward Cattua, M.D., Chief, Clinical Endoscopy, National Institute of Health; and Peter L. Plumeri, D.O., J.D., Sewell, NJ. Doubletree, Lincoln Centre, Dallas, Texas. 6.5 Category I credit hours. For further information, AOES, 409 North University, Little Rock, AR 72205.

JULY 7-9

Medical Staff Issues. Sponsored by Joint Commission on Accreditation of Health Organizations. The Wort Hotel, Jackson Hole, Wyoming. Eleven hours Category I credit. Fee: $435. Phone reservations, Joint Commission, (312) 624-6061 (Visa or Master Card). Hotel reservations, 1 (800) 322-2727.

JULY 13-17

Utilization Management: Responding to New Challenges (A Medical Directors Division Conference). Sponsored by the Group Health Association of America, Inc. Wyndham Franklin Plaza, Philadelphia, PA. 12 Category I credit hours; 14.3 CEU's. Advance registration 21 days prior to meeting: GHAA member, $450; GHAA non-member, $510. On-site registration, GHAA member, $515; GHAA non-member, $575. Hotel reservations can be made by calling 1 (215) 448-2000. Further conference information, (202) 778-3228.

JULY 20

Symposium on Asthma. Sponsored by Washington University School of Medicine. Presented by Phillip E. Korenblat, M.D. Washington University Medical Center, St. Louis, MO. 8.5 Category I credit hours. Fee: $35.00. Further information, Cathy Caruso, Washington University Medical Center, 660 South Euclid, Box 8063, St. Louis, MO 63110; 1 (800) 325-9862.

JULY 29

Sports Medicine Symposium. Sponsored and presented by the Baptist Medical Center. Further information, Baptist Medical Center, Medical Education Department, (501) 227-2672.

JULY 23-28

Physicians and Their Families. Sponsored by the Menninger Clinic. Presented by Roy W. Menninger, M.D. and Bev Menninger; Becquer Benalcazar, M.D., and Regine Benalcazar-Schmid, M.D.; Glen O. Gabbard, M.D., and Joyce Davidson Gabbard, M.D.; Joseph Hyland, M.D., and Patricia Spiegelberg Hyland, M.D.; and Martin B. Leichtman, Ph.D. and Maria Louisa Leichtman, Ph.D. Grande Butte Hotel, Crested Butte, Colorado. Fee: $595 per couple. Deadline for registration June 30, 1989. 22.5 Category I credit hours. Further information, Jayne Roberts, Division of Continuing Education, The Menninger Clinic, Box 829, Topeka, KS 66601-0829; 1 (800) 288-7377, ext. 5994.

KEEPING UP

Cholesterol: Current Concepts for Physicians

Self-Study Course for Physicians. Sponsored by the National Heart, Lung and Blood Institute. A national cholesterol education program is available through the Arkansas Medical Society office in which a physician studies at home. Two Category I credit hours. Further information: David Wroten, Arkansas Medical Society, Post Office Box 5776, Little Rock, AR 72215; (501) 224-8967.

Battering Families

June 20, 12:30 p.m. Presented by Don Beebe, LCSW. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center. One Category I credit hour.

11th Annual Family Practice Intensive Review

June 23-25, Friday and Saturday, 8:00 a.m. - 5:00 p.m.; Sunday, 8:00 p.m. - 2:30 p.m. Registration at 7:30 a.m. Presented by Ben N. Saltzman, M.D. Sponsored by UAMS. UAMS Education Building, Room G/131. 20.25 Category I credit hours. Fee: $200, physicians; $100, physician assistants; $35, residents.

Bronchitis

July 6, 12:00 noon. Presented by Phillip Duncan, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room Sparks Regional Medical Center.

Anemia - Polycythemia in Newborns

July 12, 12:00 noon. Presented by Paul Grim, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Out of Control Teenagers

July 21, 12:30 p.m. Presented by Toni Loftin, M.S. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Tumor Conference

July 25, 12:00 noon. Presented by W. J. Burt, M.D. Sponsored by AHEC Fort Smith. Fourth Floor Conference Room, Sparks Regional Medical Center.

Sports Medicine Symposium

July, 29. Sponsored by Baptist Medical Center. J. A. Gilbreath Conference Center. For further information, contact the Baptist Medical Center.

Hypergylcemia and Complications

August 3, 12:30 p.m. Presented by Ron Robinson, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

42nd Annual Scientific Assembly of the Arkansas Academy of Family Physicians.

August 10-13. Presented and sponsored by AAFP. Excelsior Hotel and Statehouse Convention Center, Little Rock, AR. Final program, times and fees to be announced. CME credit available. Futher information, contact AR Academy of Family Physicians; 11330 Arcade Drive, Suite 8, Little Rock, AR 72212; (501) 223-2272.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), Fridays, 12:15 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, Sturgis Building, Room 121
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Second Floor Classroom
Pediatric Research Conference, third Monday, 12:00 noon, Sturgis Building, Rooms S120-121
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Cancer Conference, first Wednesday, 12:00 noon, CARTI Auditorium. A meal is provided.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell Room A meal is provided.
General Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. A meal is provided. (July 4th meeting cancelled).
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. A meal is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Arkla Room. Refreshments are provided. (July conference rescheduled to July 11, same time and location).
Pediatric Conference, first Tuesday, 12:30 p.m., LaHarpe de Paul Room. A meal is provided. (No conference in July)
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
GI Conference, third Thursday, 12:00 noon, Conference Room 1.

Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS Education Building, Room G137, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B.
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH.
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33.
Ob/Gyn Grand Rounds, Wednesdays, 7:30 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Fundamental Sciences Conference, first Tuesday, 6:00 p.m., UAMS Chancellor's Area, Conference Room B-2
Surgery Grand Rounds, one Saturday per month, 8:00 a.m., UAMS Education Building, Room G/141A, 1.5 credit hours
Surgery Morbidity and Mortality Conference, Wednesdays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Resident Case Conference, Mondays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Review Conference, Mondays, 6:00 p.m., UAMS Education Building, Room G/141A
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Conference (Pediatric), once monthly, 5:00 p.m., Arkansas Children's Hospital, Sturgis Building, Clinic 2
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
*Urology Morbidity and Mortality Conferen*ce, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Tuesdays, 5:00 p.m., UAMS Education Building, Room G/131A&B

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:15 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:15 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:15 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:15 p.m., AHEC - South Arkansas

Obstetrics-Gynecology Conference, fourth Thursday, 12:15 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:15 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:15 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
Family Medicine Conference, varying dates through April, May, and June, 1:00 p.m., AHEC - NW, 241 W. Spring, Fayetteville. Contact AHEC - NW for list of dates.
Nephrology Lecture Series, fourth Thursday, 12:30 p.m., AHEC- NW, 241 W. Spring, Fayetteville
Rheumatology Lecture Series, first Tuesday, 12:30 p.m., VA Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village.
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff.
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

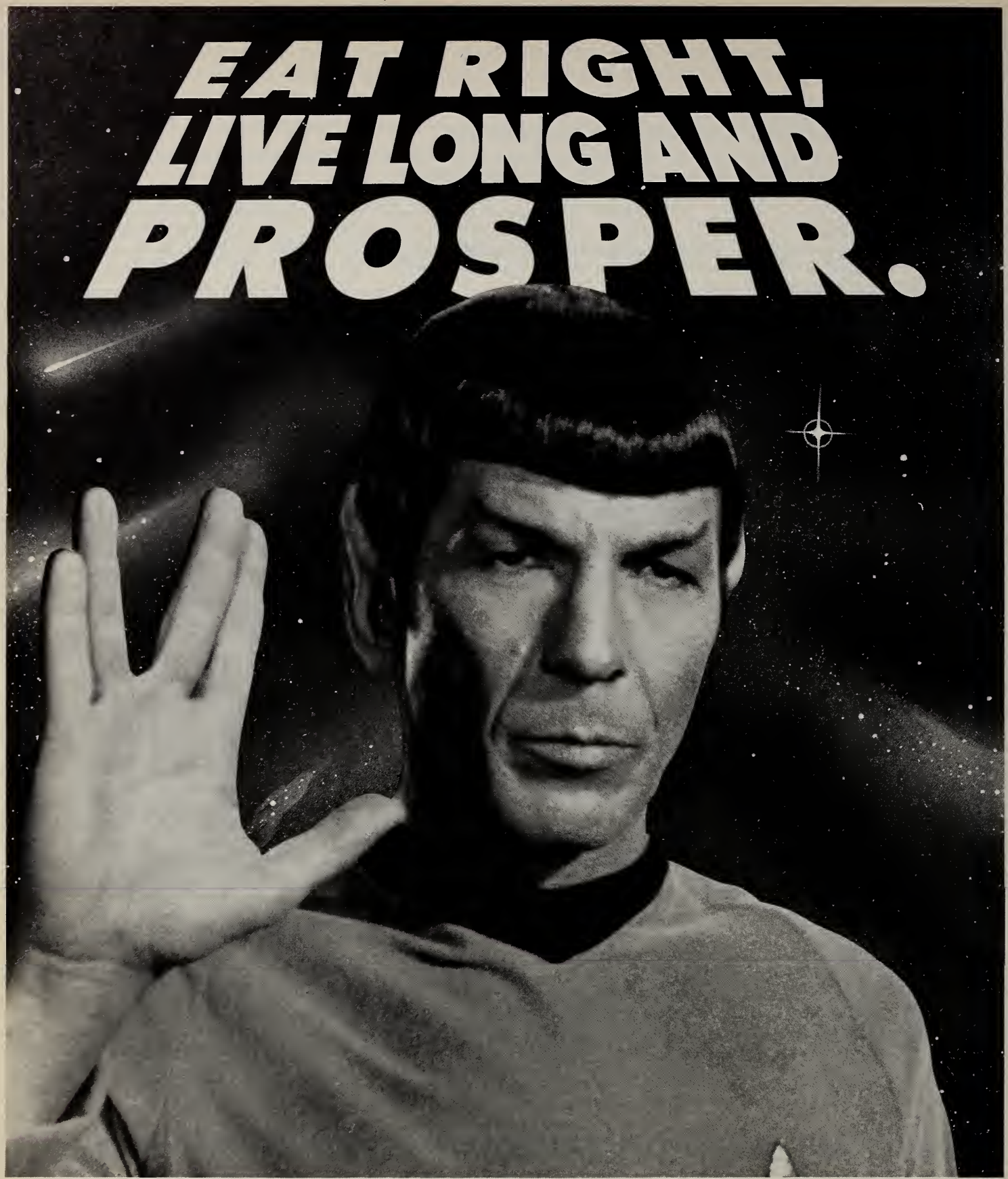
Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, second and fourth Wednesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

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MEDICINE IN THE NEWS

New AMA Book Offers Help on Starting and Managing A Successful Practice

Physicians who plan to start private practices or those who wish to review the fundamentals of practice management will benefit from the newly revised and expanded edition of *The Business Side of Medical Practice*.

Available from the American Medical Association, the book is designed to provide information needed to successfully start and manage a medical practice. Topics new to this edition are computers in the medical office and up-to-date information on the pros and cons of the various legal forms of organizing a practice.

Many chapters in the book focus on deciding how to practice, selecting the place to practice, setting up an office, clearing legal hurdles and securing professional assistance, and the kinds of insurance a physician should carry.

Major helpful tips and guidelines will be found in the chapters on efficiency and office operations, running the business side of practice, billing and collections, and personnel management. Another chapter addresses personal financial planning.

Throughout the book are various forms, charts, and checklists which may be reproduced and used by office staff.

The Business Side of Medical Practice, is available for $30 (20% discount for AMA members), from the American Medical Association, Book and Pamphlet Fulfillment, Post Office Box 10946, Chicago, IL 60610-0946 or call 1 (800) 826-6895 with VISA or MasterCard orders.

Dial Access: Continuing Medical Education by Toll-Free Telephone

A rural Georgia physician recently was faced with a tough medical dilemma - how to treat a pregnant woman discovered to have tuberculosis without harming her unborn child. He dialed a toll-free 800 number, listened to a short audiotape on "The Management of Tuberculosis During Pregnancy" and within minutes learned what drugs to prescribe without harming mother or baby.

Since 1978, that physician and more than 250,000 others have used a Southern Medical Association-sponsored hotline to get instant access to the latest medical information, 24 hours a day, 365 days a year.

The hotline is Dial Access, a unique continuing medical information service provided by the Southern Medical Association. Dial Access is available by subscription to any physician or allied health professional in the continental United States.

The system now contains more than 800 tapes in nine different categories: Arthritis & Rheumatism, Diabetes & Endocrinology, Gastroenterology, Infectious Diseases, Obstetrics & Gynecology, Psychiatry, Cancer, Cardiovascular Diseases, and Allergy & Immunology. Critical Care-Emergency Medicine and Geriatrics will soon be added.

Each category has its own editor who selects the tapes to be included and the experts to write them. The editors are preeminent in their fields and serve on the faculty of leading medical schools or research institutions throughout the U.S.

The programs are revised regularly and are prepared under the guidelines of the Essentials for Enduring Materials of the Accreditation Council for Continuing Medical Education.

Beyond its benefit as an accessible source of relevant, practical medical information, Dial Access is free of time and place constraints. Regardless of where the physician lives, his type of practice and patient load or income, Dial Access is available as a ready resource. For more information, call 1 (800) 423-4992.

Rural Medical Clinic Revolving Loan Fund

The Office of Primary Care, through the State Board of Finance, administers the Rural Medical Clinic Revolving Loan Fund. This fund provides assistance to communities and physicians for the construction, renovation, or equipping of medical clinics in rural areas. The Office of Primary Care gathers data and make recommendations to the Board of Finance on funding priorities.

For physicians, loans are available up to $12,000 and are payable at 5% interest over 6 years. For community groups, loans/grants are available up to $10,000 and loans are payable over 10 years. The intent of the fund is to encourage physicians to move into rural areas of less than 7500 population. Any community or rural practitioner who meets the established criteria may receive assistance from the fund.

For further information on the application process for the Rural Medical Clinic Revolving Loan Fund, please contact, Sandra Wilson, Office of Primary Care, 4815 West Markham, Little Rock, AR 72205; (501) 661-2194.

Lamberts (Dalston) Limited to Distribute Cervical Cap

Cervical Cap Limited announced recently that it has signed an exclusive agreement with Lamberts (Dalston) Limited, of Luton, England, to distribute the Prentif™ Cavity-Rim Cervical Cap in the United States and Canada.

The U. S. Food and Drug Administration (FDA) approved the use of the Prentif™ Cavity-Rim Cervical Cap on May 23, 1988. Prentif is the only cervical cap approved for use in the United States by the FDA. Over ten years

extensive clinical studies involving more the 50,000 women preceded the FDA approval.

The cervical cap is a barrier method of contraception which is placed over the cervix to prevent sperm from entering the uterus. It is thimble-shaped and made of latex rubber, with a firm yet pliant rim. The cap is a prescription device, initially fitted by a physician. Women are taught to use it and then can place and remove the cap themselves.

By the request of the FDA, the National Institutes of Health funded a study on the cervical cap's effectiveness. Dr. Gerald Bernstein, professor of obstetrics and gynecology at the University of Southern California, conducted this study which compared cap effectiveness with that of the diaphragm. Results indicated "there was no statistically significant difference between the overall pregnancy rates for the cap and diaphragm users." A randomized comparison study of the cervical cap demonstrated a one year pregnancy rate for the cap at 17.4 per 100 users. The diaphragm pregnancy rate was 16.7 per 100 users.

The cervical cap is not recommended for those patients with an unusually long or short cervix or an unusually shaped or asymmetrical cervix, a history of cervical lacerations or scarring, current cervicitis or vaginal infections or abnormal Pap smears.

The cervical cap offers women advantages as a method of contraception. Unlike the diaphragm, the cap does not require additional spermicide before each act of intercourse. A women can wear the reusable device for 48 hours, allowing spontaneous protected intercourse. The cervical cap is smaller than a diaphragm, and less noticeable to the partner. The device is a good alternative for women who cannot use the diaphragm because of pelvic infections or irregular bleeding, as is the IUD. No reports of cases of toxic shock syndrome has been associated with cervical cap use.

For additional information on Cervical Cap Limited (C_xC) or the Prentif™ Cavity-Rim Cervical Cap, contact: Cervical Cap Limited (408) 358-6264.

TAKE THE FIRST STEP TO RECOVERY

The Physicians' Health Committee exists for you, the physician who is struggling with drug or alcohol addiction. The committee is composed primarily of physicians who have "been there" and want only to help their colleagues from making the same mistakes.

The Committee members are willing to set up interventions, recommend treatment, and help with aftercare and re-entry.

The Committee is not involved in any legal, moral or punitive judgements.

ON CALL FOR YOU

Don't throw away your profession because of drugs and alcohol. Contact our Physicians' Confidential Assistance Hotline at (501) 370-8221. Only specially trained personnel will return your call. Or contact the Arkansas Medical Society office at (501) 224-8967 or 1-800-542-1058 and ask for the name of one of the Physicians' Health Committee members.

All inquiries are confidential within the Committee and no names or locations are necessary when contacting the Society office.

New Members

BENTON COUNTY MEDICAL SOCIETY

Moffitt, Gary L., Family Practice, Rogers. Born June 1, 1954, Pontiac, MI. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1977. Medical education, University of Arkansas for Medical Sciences, 1981. Internship/residency, UAMS, AHEC Northwest. Practice experience, 5 years, Rogers. Board certified.

CARROLL COUNTY MEDICAL SOCIETY

Spurgin, Randal T., Family Practice, Berryville. Born March 22, 1955, Ada, OK. Pre-medical education, Arkansas State University, Jonesboro, B.S., 1977. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, UAMS, AHEC NE. Practice experience, 6 months, Berryville. Board certified. Member, AAFP.

JEFFERSON COUNTY MEDICAL SOCIETY

Washington, Erma S., Obstetrics/Gynecology, Pine Bluff. Born May 18, 1957, Chicago, Illinois. Pre-medical education, Fisk University, B.A., 1978. Medical education, Meharry Medical College, Nashville, Tennessee, 1982. Residency, Wayne State University. Practice experience, 1 year, Detroit, Michigan; 2 years, Pine Bluff. Board certified, obstetrics and gynecology. Member, American College of Obstetricians and Gynecologists.

RESIDENT SECTION

Wilson, John D., Radiology. Born March 16, 1959, Lewistown, Pennsylvania. Pre-medical education, University of North Carolina, Chapel Hill, B.S., 1982. Medical school, University of North Carolina, 1988.

In Memoriam

DR. PAUL LEEDS ROGERS

Dr. Paul L. Rogers, 57, of Charleston, died Monday, April 24, 1989. Before his retirement in 1985, Dr. Rogers was radiologist at the Cooper Clinic in Fort Smith as well as former chief of staff of St. Edward Mercy Medical Center.

Dr. Rogers had held the position of radiology department medical director at St. Edward's and was an assistant professor of radiology at the University of Arkansas Medical Center. He also taught with the AHEC residency program.

Dr. Rogers was active as the president of the arts and theater community. He had been a member of the board of Abilities Unlimited, the United Way of Fort Smith as well as being on the advisory board of the Junior League of Fort Smith.

He was a member of the American Medical Association and an emeritus member of the Arkansas Medical Society. He was a past president of the Sebastian County Medical Society. Specialty group memberships included being a charter member of the American Society of Nuclear Medicine and a past president of the Arkansas Chapter, American College of Radiology.

Dr. Rogers is survived by his wife, Maude Jeter Rogers; three sons, Paul L. Rogers of Pittsburgh, Chris T. Rogers of Arlington, VA, and Gill Rogers of Little Rock; and his mother, Marie Rogers of Shreveport, LA.

DR. IRVING J. SPITZBERG

Irving J. Spitzberg, M.D., a retired Little Rock diagnostician and pediatrician, died Saturday, May 6, 1989. He was 89.

Early in his career, Dr. Spitzberg was a professor of pediatrics at the University of Arkansas medical school and became the head of the department of pediatrics in the early 1930s. He began the school's first scholarship program for nurses in 1957.

Dr. Spitzberg was a staff member at most of the Little Rock area hospitals and was active with medical projects for the Arkansas Senior Citizens. He was a member of the staff of Polio Pioneers, which contributed to the success and implementation of the Salk vaccine.

Dr. Spitzberg was a fellow of the American Academy of Pediatrics, a life member of the Southern Medical Association as well as a member of the American Medical Association, the Arkansas Medical Society and the Pulaski County Medical Society.

Dr. Spitzberg was an American Legion post commander and served in World War I.

Survivors include his wife, Marie Spitzberg; two sons, Paul Spitzberg of Tenafly, NJ and Irving Spitzberg of Silver Springs, MD; two brothers, Henry Spitzberg of Little Rock and Dr. Randolph Spitzberg of Baltimore; a sister, Louise Rosenberg of Dallas; and four grandchildren.

RESOLUTIONS

Irving J. Spitzberg, M.D.

Whereas, the members of the Pulaski County Medical Society are truly saddened by the recent death of an esteemed colleague, Irving J. Spitzberg, M.D., and

Whereas, Dr. Spitzberg was a member of this Society for over forty-five years, and was highly respected as a leader in his chosen field of pediatrics, and

Whereas, his concern for his patients and for his country was clearly evidenced by the many hours he contributed to the health care of poor children at Arkansas Children's Hospital and by his military service in World War I, be it therefore

RESOLVED, that this resolution be adopted as a token of our appreciation for Dr. Spitzberg's life and service; and

RESOLVED, that a copy be sent to Dr. Spitzberg's family as an expression of our heart felt sympathy; and

RESOLVED, that a copy be made available to the *Journal of the Arkansas Medical Society* for publication.

By Order of the Memorials Committee
Adopted Unanimously — *Marlon Doucet, M.D., Chairman*
Executive Committee — *Henry Hollenberg, M.D.*
May 17, 1989 — *Robert Watson, M.D.*

"Drew County Arkansas History of Medicine"

The Drew County Historical Museum is pleased to announce the availability of a new publication, "Drew County Arkansas, History of Medicine" written by Dr. and Mrs. Johnnie Porter Price. The 230-page soft cover book includes a historical perspective of 100 years of medicine in Drew County and over 160 biographical sketches of the physicians of the county, some dating as far back as 1804.

To purchase the book, make your check or money order for $26.50 ($25.00 purchase price and $1.50 postage and handling) payable to Drew County Historical Museum, 404 South Main, Monticello, AR 71655; (501) 367-7446 or you can contact Mrs. J. P. Price, 232 South Main, Monticello, AR 71655; (501) 367-5100.



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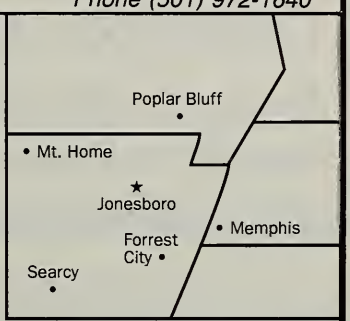
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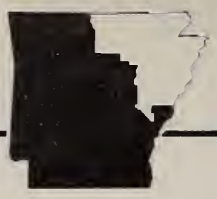
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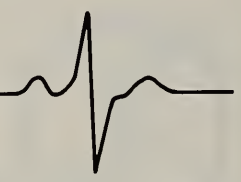
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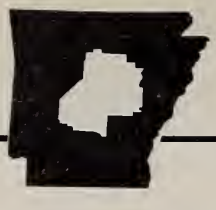
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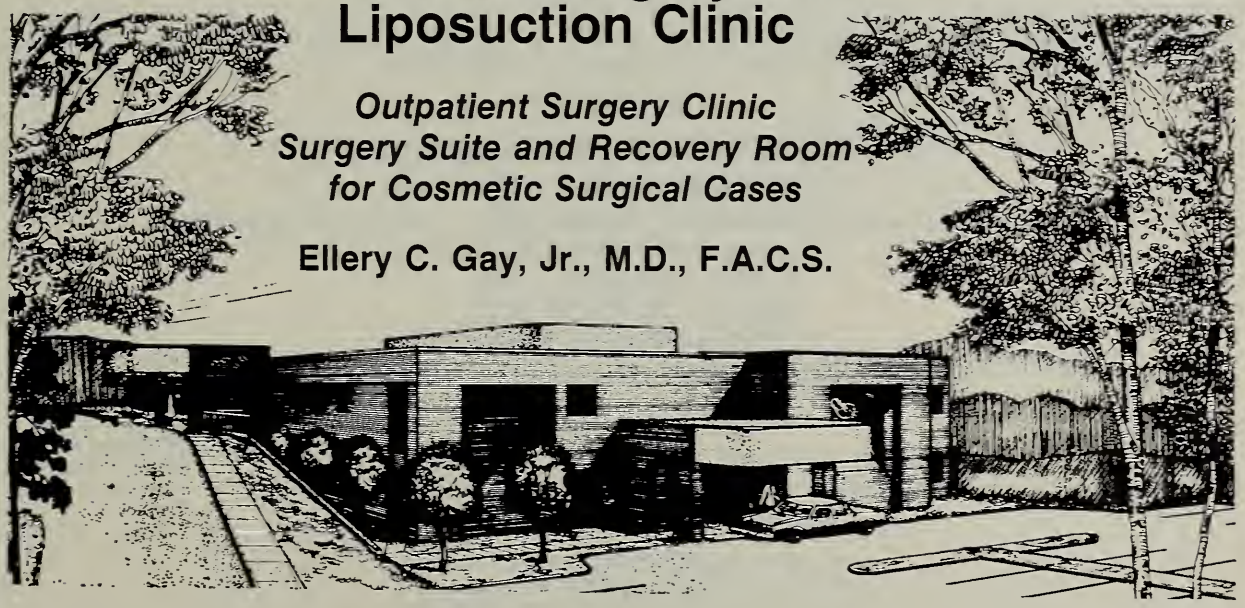
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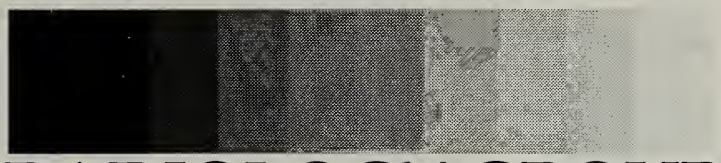
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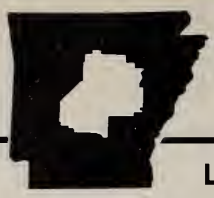
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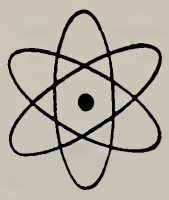
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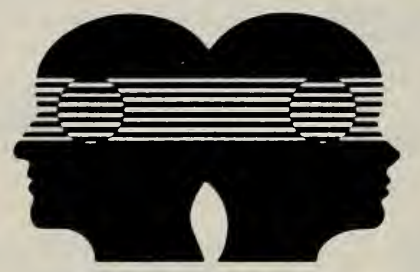
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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 298 patients.

Hypertension: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

Heart Failure: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy.

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J6VS18R(815)

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On our Cover: Arkansas' many lakes are a great place to spend the summer. Pictured is Beaver Lake in Northwest Arkansas. Photo supplied by the Arkansas Department tof Parks and Tourism.

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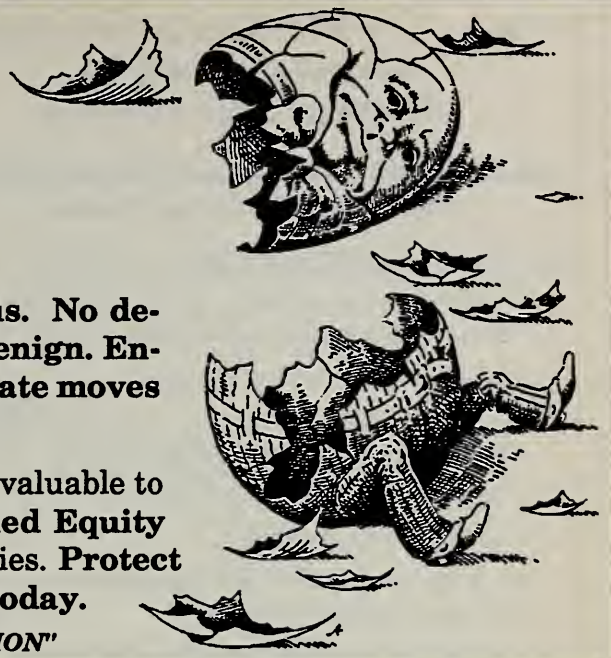
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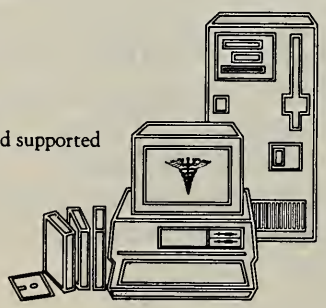
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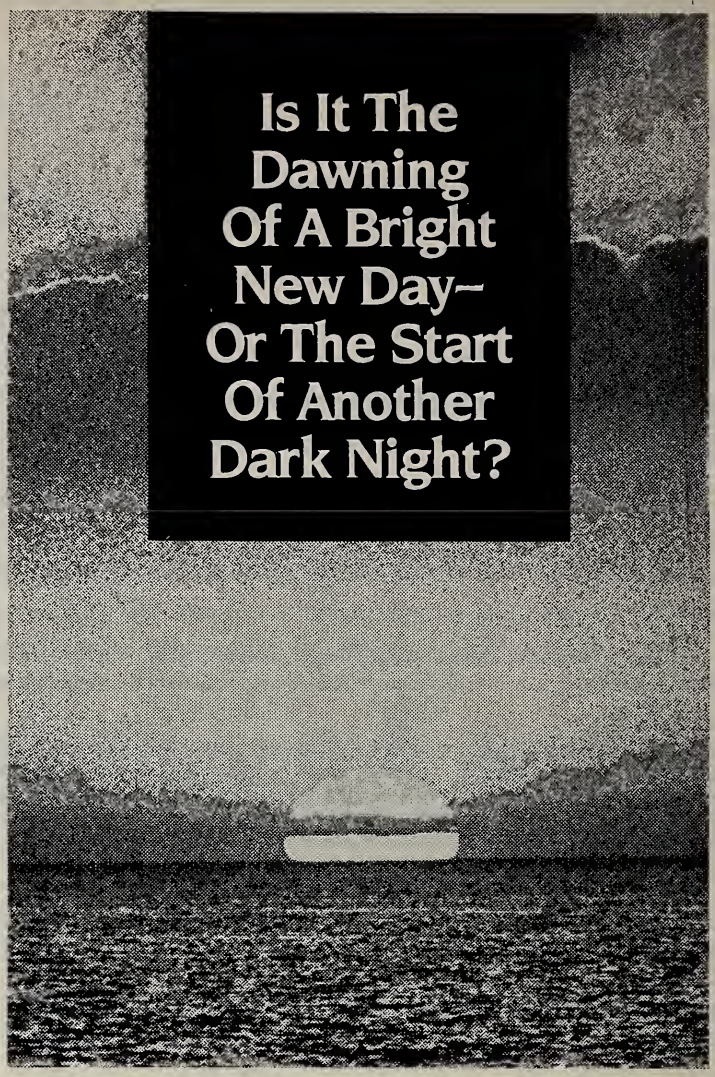


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AIDS IN ARKANSAS

AMS Special Committee on AIDS — William N. Jones, M.D., Chairman

Update July 1989: AIDS-Related Services in Arkansas

*Gene Stanford, Ph.D.**

Introduction

Acquired Immune Deficiency Syndrome presents the physician with one of the most complex medical challenges of recent times. The medical management of this disease requires contributions from many medical specialty areas, since the disease can affect so many different organ systems.

Moreover, social factors add to the complexity of managing this disease. Public attitudes, ranging from ignorance to outright hostility, can profoundly influence the way the patient deals with his or her illness. Many patients experience alienation from friends and family. Others encounter overt discrimination that may result in loss of employment, insurance, housing, and access to health care.

Since AIDS in Arkansas is most likely to strike gay men or intravenous drug abusers, many AIDS patients are already dealing with unique emotional stresses, even before becoming ill. As the disease progresses, they may need concrete services not readily available in their communities, such as financial support, housing, homemaker services, and transportation.

Because the AIDS epidemic was slower arriving in Arkansas than in many other states, the development of support services for people with AIDS-related problems has been equally delayed. Fortunately, though, such services are beginning to appear. Almost all have resulted from the efforts of concerned private citizens and volunteer organizations, rather than government agencies.

Financial Assistance

Small cash grants are made to assist people with AIDS throughout the state in buying medications, paying household bills, and other legitimate expenses by a Little Rock-based organization called Helping People with AIDS. The physician must certify the diagnosis of AIDS in writing and the patient must substantiate the need. Payment is made directly to the vendor rather than to the patient. Phone 666-6900 for more information.

Fayetteville area patients with financial emergencies can contact the Washington County AIDS Task Force at 443-2437.

Information Lines

Because of the desire to protect their identities, many persons with questions and concerns related to AIDS like the anonymity of a telephone "hot line" when they need information and advice. Three such services are presently operating in Arkansas:

The Arkansas Department of Health offers a toll-free line from anywhere in Arkansas, Monday through Friday, 8:00 a.m. until 4:30 p.m. at 1-800-445-7720.

Operation Switchboard, a joint venture of the Arkansas AIDS Foundation and the Arkansas Gay and Lesbian Task Force, operates daily from 6:30 p.m. to 10:30 p.m. at 666-3340.

The Washington County AIDS Task Force sponsor an AIDS Information Line which is available from 7:00 p.m. to 7:00 a.m. daily at 443-2437.

Patient Support Groups

A free support group for persons who are HIV positive or have AIDS or ARC meets each Monday at 6:30 p.m. at 210 Pulaski Street in Little Rock. Dr. Ralph Hyman, a licensed psychologist, leads the weekly discussion of members' thoughts, feelings and needs. For more information, call 374-3605 or 663-7833.

Another free group for patients has more of an education focus, teaching patients to maintain their health through strategies such as positive attitudes, self-care, nutrition,

* *President, Arkansas AIDS Foundation and Director, Human Services, Arkansas Children's Hospital, 800 Marshall, Little Rock, Arkansas 72202-3591.*

exercise, and stress management. It meets every Thursday at 6:45 p.m. in the Peck Education Building at St. James Methodist Church, 321 Pleasant Valley Drive in Little Rock. Call Dr. Virginia Vollmer at 666-5511 for additional information.

The Fayetteville support group for people with AIDS/ARC meets every Tuesday. The Washington County AIDS Task Force also sponsors a drop-in center on Friday afternoons. Call 443-2437 for more information.

Information about a support group in El Dorado can be obtained by calling Mr. Winn at 862-7921.

In Texarkana, contact Audrey Norwood at (214) 793-5602.

Information about Fort Smith AIDS support group is available from Dr. Jimmy Acklin at 785-2431.

`The Fort Smith AIDS Helpline operates from 7:00 p.m. to 7:00 a.m. at 782-7710.

Individual Support and Counseling

Some patients may be reluctant to attend a group meeting because they fear it will result in public exposure of their health status. In smaller communities throughout the state, no support groups exist because the number of patients is low. In both these cases, patients may be referred to an individual in their community who has been trained by the Arkansas AIDS Foundation to provide support, information and counseling to persons with AIDS-related concerns. Contact the Foundation at 663-7833 for a referral.

Buddy Program

Buddies are trained volunteers who assist people with AIDS (either at home or in the hospital) with daily activities and provide support and companionship. For assignment of a buddy from the Arkansas AIDS Foundation, call Dr. Kurt Wilhelm at 378-0300. In the Fayetteville area, call the Washington County AIDS Task Force at 443-2437.

Family Support Group

A no-cost support group for family members and significant others of people with AIDS and ARC and those who are HIV positive is sponsored by the Arkansas AIDS Foundation. Led by an experienced social worker, it meets every Monday from 6:30 p.m. to 8:00 p.m. at 210 Pulaski Street in Little Rock. For information call Lewis Lefebvre at 851-8690.

Caregivers' Support Group

For social workers, nurses, other health care workers, and volunteers, the Arkansas AIDS Foundation sponsors a monthly support group where those who work with people with AIDS can network, share ideas and collaborate on projects. The group meets at 7:00 p.m. in Room 64 of the Education Building at Second Presbyterian Church, Pleasant Valley and Cantrell in Little Rock on the first Thursday of each month. Call 663-7833 for details.

Testing and Counseling

Persons who wish to be tested for exposure to HIV can receive pre- and post-test counseling and confidential testing for a charge of $4.00 at thirty-four test sites operated by the Arkansas Department of Health. Call 1-800-445-7720 for the location of the most convenient site.

Free counseling and testing are offered by the Arkansas AIDS Foundation in Little Rock on the second and fourth Tuesday evenings of each month. Call 663-7833 for details.

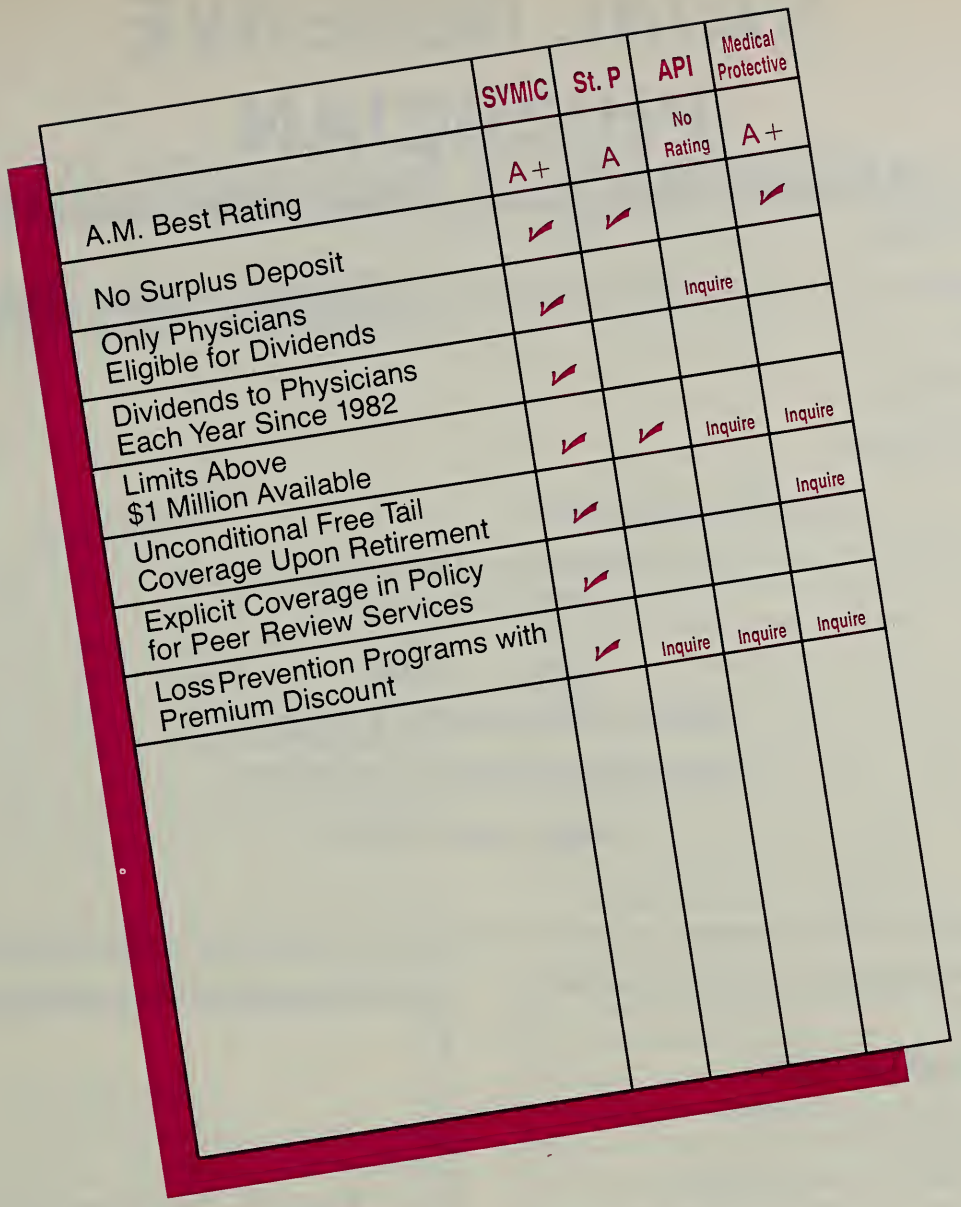
All of these services welcome individuals from all backgrounds, regardless of how the disease was acquired, and they do not discriminate on the basis of race, religion, gender, sexual orientation, age or handicap.

Bridges Surgical Clinic seeking an Internist, or Family Practitioner and General Surgeon. For more information, call or write to: Bridges Surgical Clinic, 128 Homer Road, Minden, Louisiana 71055, 318-377-1436 M-F; 318-377-1429 S-S.

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Anabolic Steroid Legislation Act 249 of 1989

Don Phillips, P.D.[*]

Abstract

Health care professionals are urged to be alert to the potential for adverse effects common to the use of anabolic steroids by athletes and others, including high school and college students active in varsity sports or body lifting.

The Department of Health, Division of Pharmacy Services and Drug Control asks for cooperation and assistance in helping combat the illegal diversion by physicians and pharmacies of these hazardous drugs and to ensure that these drugs are available to patients only through legitimate channels.

Act 249 of 1989 was enacted to prevent the distribution and use of illegal anabolic steroids and growth hormones and for purposes of defining and setting penalties for the illegal use.

Introduction

The abuse of any drug is a public health concern. Particularly the uses of controlled substances such as alcohol, cocaine, amphetamines, and narcotics. While the abuse of these habit forming substances presents a problem, this paper will be limited to the topic of anabolic steroid abuse.

The use of anabolic steroids by athletes who wish to increase lean body mass and improve muscular strength is widespread, especially among elite weight-trained athletes. Currently, combinations of injectable and oral preparations of steroids are used by athletes at doses 10 to 100 times greater than the dose any physician would legitimately prescribe.[1] The doses used by physicians in controlled studies are considered by athletes to be ineffective.[2]

Athletes have little difficulty in obtaining anabolic steroids. Unfortunately, there are some physicians and pharmacists who will provide these drugs. More often, steroids are obtained in the "black market" around certain gym's, health clubs, and body building facilities. Sources include coaches, sports trainers, other athletes, and mail-order houses that specialize in the distribution of steroids.

There are controversies concerning the value of steroids. There are side effects and the ethical questions concerning their use. Athletes use steroids to increase lead body mass and improve muscular strength. The amount of weight gained in training studies has been relatively small. The gains in muscular strength achieved through high-intensity exercise and proper diet can be increased by the use of steroids in some individuals. Anabolic steroids have been associated with adverse effects on the liver, cardiovascular system, and reproductive system. Some of these adverse effects are potentially hazardous.

Public awareness of the problem is increasing. It would not be an exaggeration to state that every large circulation newspaper in the nation has carried a major story concerning the abuse of anabolic steroids by the athletic community. In a recent study published in the *Journal of the American Medical Association* and commented on in the press, the investigators estimated that as many as 500,000 high school students (7%) may be taking anabolic steroids to enhance their athletic performance or physical appearance. The study also found that more than one-third of surveyed users first took anabolic steroids at age 15 or younger (ages at which their bodies had not yet fully developed and were very vulnerable to the effects of such potent drugs). The survey looked at anabolic steroid use among 3,400 male students in 46 private and public high schools across the country. The FDA believes that the percentage of high school students using anabolic steroids is higher. A 10% figure is a more accurate one.

As recently as 1986, the FDA estimated the value of the anabolic steroids black market at $100 million annually. According to the *Washington Post*, it is believed by some federal officials that the best current estimate lies in the range of $400 to $500 million annually - a staggering 4 to 5 fold increase in only three years.

Legislation

The Arkansas 77th General Assembly passed a Legislative Act concerning anabolic steroids and growth hormones. Highlights of Act 249 of 1989 are shown in Figure I.

[*] *Division of Pharmacy Services and Drug Control, Arkansas Department of Health, 4815 West Markham, Little Rock, Arkansas 72205-3867.*

Figure I. ACT 249 of 1989

Defines "anabolic steroid" as any isomer, ester, salt, or derivative of the following that acts in the same manner on the human body:

(a)	clostebol	(j)	methyltestosterone
(b)	dehydrochlormethyltestosterone	(k)	nandrolone
(c)	ethylestrenol	(l)	norethandrolone
(d)	fluoxymesterone	(m)	oxandrolone
(e)	human growth hormone	(n)	oxymesterone
(f)	mesterolone	(o)	oxymetholone
(g)	methandienone	(p)	stanozolol
(h)	methandrostenolone	(q)	testosterone
(i)	methenolone		

Defines "counterfeit substance" as a drug which, or the container or labeling of which, without authorization, bears the trademark, trade name, or other identifying mark, imprint, or device, or any likeness thereof, of a drug manufacturer, processor, packer or distributor other than the person or persons who in fact manufactured, processed, packed or distributed the drug and which thereby falsely purports, or is represented to be the product of, or to have been packed or distributed by, another drug manufacturer, processor, packer, or distributor.

Defines "human growth hormone"

Provides that any person who distributed or possesses with intent to distribute any ANABOLIC STEROID, HUMAN GROWTH HORMONE, or COUNTERFEIT SUBSTANCE purporting to be an ANABOLIC STEROID or HUMAN GROWTH HORMONE for any use in humans other than the treatment of disease pursuant to the order of a physician ***shall be deemed guilty of a class D felony.***

Provides that any person who distributes or possesses with the intent to distribute to an individual under 18 years of age, any ANABOLIC STEROID, HUMAN GROWTH HORMONE, or COUNTERFEIT SUBSTANCE purporting to be an ANABOLIC STEROID or HUMAN GROWTH HORMONE for any use in humans other than the treatment of disease pursuant to the order of a physician ***shall be deemed guilty of a class C felony.***

Provides that possession by any person of more than 200 capsules or tablets or more than 16 cc of ANABOLIC STEROIDS, HUMAN GROWTH HORMONES, or COUNTERFEIT SUBSTANCES purporting to be an ANABOLIC STEROID or HUMAN GROWTH HORMONE shall create a rebuttable presumption that the person possesses such substances with the intent to deliver in violation of the aforementioned sections (i.e., previous two paragraphs) dealing with penalties for the illegal distribution of such.

Conclusion

The magnitude and complexity of anabolic drug diversion from legitimate sources compels us to take responsibility in effectively addressing this problem by enforcing the laws and regulations as they pertain to the legitimate prescribing and dispensing of anabolic steroids.

Practitioners must take individual responsibility for themselves first, and secondly, for their colleagues who may be deceived or dishonest in their prescribing habits.

The associations and societies must ensure that continuing education is received by their members and that peer assistance groups are established and a network to assist physicians in identifying "scams" and "doctor shoppers" attempting to get a supply of anabolic steroids for black market sales. Even though we may have little control over the black market street sales and distribution of anabolic steroids, we do have an obligation to assure that we are not contributing to the problem.

The Division of Pharmacy Services and Drug Control, Arkansas Department of Health is responsible for the enforcement of the laws as they pertain to the legitimate prescribers and dispensers of anabolic steroids, and we intend to proceed with a coordinated and comprehensive strategy against this problem of diversion for illegal use of these drugs.

We would appreciate reports from physicians of adverse effects and deaths believed to be associated with the abuse of anabolic steroids, as well as information gained regarding the source of these illegal drugs. To report, you may call 661-2325.

References

1. Lamb DR. Anabolic steroids in athletics: how well do they work and how dangerous are they? AM J Sports Med 1984; 12(1):31-8.
2. Bergman R, Leach RE. The use and abuse of anabolic steroids in Olympic-caliber athletes. Clin Ortho and Related Research 1985; 198:169-73.

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

SPECIAL ARTICLE

Malpractice Insurance Made Easy?

Z. Lynn Zeno
Arkansas Medical Society
Director, Governmental Affairs

Presently, most Arkansas physicians enjoy reasonable malpractice insurance premiums when compared to colleagues in other states. With the exception of a few specialties, such as OBG's, there are several competitive insurance carriers vying for your business. Because of the variety of insurance carriers and available policies, this primer has been prepared to help physicians understand malpractice insurance terminology.

What is an Occurrence Policy?

"Occurrence" policies cover you for any claim *that occurred* while the policy was in effect. Example: You had an occurrence policy with XYZ Company in 1985 and you are sued in 1989 for care you provided in 1985. Under the *occurrence* policy, XYZ Company would be responsible for your coverage because the alleged malpractice occurred during their policy period. XYZ Company is responsible even if you are no longer insured by their company.

What is a Claims-Made Policy?

"Claims-made" policies provide coverage for claims *filed* while the policy is in effect for care *delivered only while the policy is in effect.* Example: You had claims-made coverage with ABC Company in 1985. You changed companies and you are sued in 1989 for care provided for in 1985. ABC Company would not be responsible for the malpractice action *because* the claim *was not filed* during the policy period. *You would be covered only if you had purchased a "tail" policy from the first insurance company or if you had obtained "prior acts" coverage from your new insurance company.*

What is a Tail Policy?

As mentioned earlier, "claims-made" policies cover you only for those claims *filed* while the policy is in force. If you cease to practice or change insurance carriers, you will need to purchase a "tail" policy (also known as an extended reporting endorsement) to cover you for acts that may have been committed while the claims-made policy was in effect, but were not filed until after that policy had expired. This separate policy should provide coverage for an indefinite period of time and is supplied by the carrier that wrote the claims-made policy. The premium for "tail" coverage is expensive and is usually priced at one and one-half to two and one-half times the current annual premium.

What is Prior Acts Coverage?

Some policies offer coverage for acts that occurred prior to the period of your current policy coverage. Prior acts coverage may be desirable if your previous policy was claims-made because prior acts coverage is often less expensive than tail coverage, yet provides the same protection. As an enticement to new insureds, some companies offer to pick up prior acts coverage at no charge, thereby negating the need to purchase expensive tail coverage.

What are Policy Limits?

The dollar limits of your coverage are usually expressed as two numbers such as $500,000/$1,000,000 or $1,000,000/$3,000,000. The first number is the maximum amount of insurance the company will pay for one suit; the second number is the limit the company will pay for all suits filed for care delivered in any one policy year. Factors in determining how much coverage to buy include such things as: what is required by the hospital in which you practice; what is the geographic norm for physicians in similar practice; and, how much coverage you need to protect all your assets. Particular attention should be paid to single policies that cover a group of physicians. Do the policy limits apply to each physician, or the entire group? If they apply to the entire group, some members might be denied coverage for suits filed after the group's limit has been reached in any policy year.

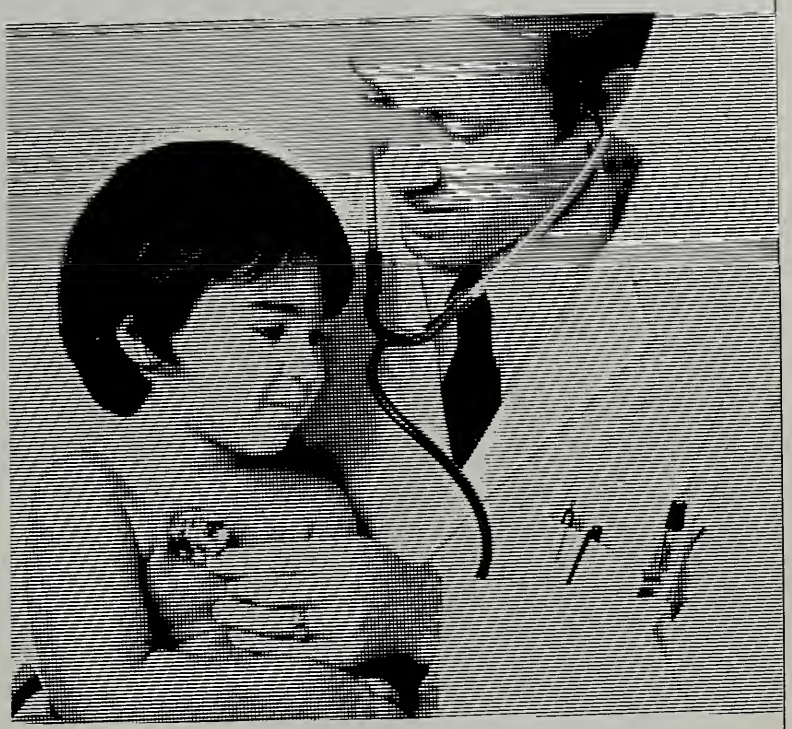
Conclusion

A physician's decision on malpractice insurance may be one of the most important decisions he makes. Nothing could be more detrimental than to be involved in a malpractice suit and discover that you are not protected by your malpractice policy.

Make sure you are working with a financially sound company; licensed by the State Insurance Department; with a knowledgeable agent; and a proven track record of successful defense work. Remember, if a company offers a deal that is too good to be true...it usually is!

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Are Practice Guidelines Cookbook Medicine?

Lucian Leape, M.D.
Harvard School of Public Health
Consultant to the RAND Corporation

Editor's Note: This article is a transcription of Dr. Leape's presentation to the Arkansas Medical Society during the annual meeting, April 27-29, 1989.

I have spent 20 years performing surgery and came to realize the biggest problem in medicine was that they were doing it to us and not enough of us were involved in the planning process. I took a year's internship at the RAND Corporation which is considered to be the West Point of the health care policy making field. I am trying to bridge the gap so to speak and give you some thoughts about where we stand and what the future holds concerning practice guidelines. When I get through with my talk I think you will agree. One of the reasons I came out here was to see if you agree.

I would like to address two or three questions. The first one is, what do we mean when we say guidelines? If we are going to argue and fight about guidelines then let's make sure we are talking about the same thing. What are they really suppose to do and do they do it? What are they supposed to be addressing? The problem is very simple, it is called inappropriate and unnecessary care.

There are people who believe that there are unnecessary operations and procedures being performed. Not that they are necessarily harmful but they are ineffective and not beneficial or that they are marginally beneficial.

What is the evidence of this? In 1969, Charles Lewis at the University of Kansas published the first paper on geographic variations of four or five operations in Kansas and noticed a difference in the way surgery was performed and showed there were two to three fold variations in the number of cases performed per population. Another study in 1973 involved six types of operations including tonsillectomy, hysterectomy, colostomy, herniorrhaphy, etc., in the states of Rhode Island, New Hampshire and Maine. The study involved the number of patients per 10,000 in various counties having the operations. The study indicated that there were wide variations, especially in toncillectomy. The study did not indicate as much variation in herniorrhaphy. What this indicates that there is not near as much agreement about the indications for toncillectomy as there are about hernias. Such studies as this over the past 15 years have been the basis for a lot of criticism of unnecessary surgeries.

The second bit of information has been the publication of information about second opinions. This information was used in 1975 in congressional hearings and the information came out that there were 10,000 unnecessary deaths and 2.8 million unnecessary operations being performed in the United States. This is based on information that 18% of recommended surgical procedures were not recommended after a second opinion. Obviously, this is based upon a disagreement between two surgeons and I don't find this an unusual figure. This type of information was used repeatedly by those who wanted to prove that unnecessary care was being provided.

"What do we mean when we say guidelines? What are they supposed to be addressing? The problem is very simple, it is called inappropriate and unnecessary care.

The direct measurement of the appropriateness of care is quite new. A Rand Corporation study published in *JAMA* in 1987, tried to point out the reasons for geographic variations. They set up an elaborate process for determining the appropriateness for operations. The RAND Corporation found by consensus judgement that between 17% and 32% cases they studied were done for inappropriate reasons. If you accept the premise that there are some procedures done for inappropriate reasons, let's say 10%, then the question is to determine why. I don't think it is because of greediness or anything like that. I personally have never known a

"There are over 40 diuretic preparations listed in the PDR and six different classes of diuretics. I don't know of a cardiologist, much less a generalist or internist, who can know all he needs to to know about these formulas. The real problem is transferring the scientific data that is known into useful information the physician can use."

surgeon who did a procedure he thought was unnecessary. Unnecessary surgery is done because the surgeon thinks it will be helpful or useful.

Then the question is, "Why are we doing things that are not useful"? There are a number of theories as to why this occurs. One reason is that doctors tend to practice the way their peers do. The decision to do a new operation or do an operation for a new reason is because there are others doing it. Doctors are very aware of what their peers are doing and are influenced by their teachers. They tend to perform procedures or do operations very much the same way their teachers did even though their teachers may have since changed their ideas about what is approprate.

A lot of talk has been about the economic motivation. I don't think a surgeon will perform a procedure for that purpose. On the other hand, a lot of decisions in medicine are gray areas and the decision can go either way. In those cases, there may be economic motivation. This is another reason for looking into those gray areas.

I think that there are three main reasons for having inappropriate care. First, we lack the information on effectiveness; second, we do not disseminate effectively the information we have; and third, the practice of medicine is the art of the possible and not the art of the probable. Let me explain that. For many of the things we do, in fact, probably for the great majority, there is no scientific evidence to prove that it is worthwhile. Even with the most accepted studies you cannot have evidence for all the possible uses of a certain procedure. Even when the information is known it is not handled very well or is not always applicable. For example, most studies are done in large urban teaching institutions and what works well there may not work well in other parts of the country. Even if the information were applicable it's virtually impossible for physicians to keep up. For example there are over 40 diuretic preparations listed in the PDR and six different classes of diuretics. I don't know of a cardiologist, much less a generalist or internist, who can know all he needs to to know about these formulas. There is no way for a physician to know all there is to know about the scientific evidence of anything. The real problem is transferring the scientific data that is known into useful information the physician can use.

Finally, I think the more important thing is that most of us practice medicine in terms of trying to help the patient under a given set of circumstances. What is meant by that is: If you have a patient with a problem, especially if the problem is a serious one that needs attention, you could perform an operation that might possibly help. More importantly, the patient wants something done, and you believe that there is a chance of helping the patient. The procedure represents a relatively low risk, so you will perform the procedure. On the other hand, if you knew with some degree of certainty that there is very little chance that an operation will help with, for example, a 2% chance of helping the patient, you probably would not perform the procedure. Especially if you were aware that the mortality rate with this procedure could be as high as 10%. Undoubtedly, the physician will want to do the right thing if he knows what the right thing is. The big question is, what is the right thing? So we need guidelines, we need some way to make clear what is appropriate.

At the start of the PSRO in the early 1970's we made the decision to attempt to do utilization review and pre-admission certification, but those are not really what we are talking about. Very fundamental mistakes were made when we started out with quality assurance. We began to measure before we defined what it was we were going to measure. We have never taken the first step which is to define what it is. The second step is to measure it. The measurement has been taken on a very simple and erroneous conception, that is, there is an agreement on what is right. This just isn't true. Every study that has ever been done pertaining to physician judgement indicates there is about a 20% difference of opinion, even when judging the same thing. If you have 100 radiologists reviewing films, they will disagree on about 20 of them and if you have 100 radiologists reviewing EKGs, they will disagree on about 20% of them. Even if you have the same radiologists and cardiologists look at the same studies later, they will probably disagree with themselves. This is a normal variation when you are dealing with human perception and human beings making judgements. In order to do better we must have something that is a little more scientifically valid.

There are criteria, standards, guidelines, and parameters. Criteria are the specifications of appropriateness of indications of performing a procedure or operation. This is what the RAND study has done - indicate hundreds of indications for performing an operation or procedure. The study generated a list of hundreds of criteria for specific situations where procedures were inappropriate or we don't know.

Guidelines are instructions that can be used in, and are derived from, the criteria. You can't deal with 946 criteria when you have a patient seriously ill with a disease that needs your immediate attention. The AMA uses the word parameters and they like that word. I think it is the same thing.

Standards are using criteria to measure by those who want to access quality. The kind of guidelines we are talking about would have been the product of a significant improvement in information in science. This has to do with better methods to evaluate information that is available. The RAND Corporation study is a good method because it is straight forward, understandable, and state-of-the-art.

Here is the definition of practice guidelines which I think is worthwhile: "Standardized specifications for care developed by formal process which encompasses the best scientific data with expert opinion." This involves a review of virtually all the literature written on a given subject and may involve several months on a single procedure. After the information is assembled, the RAND Corporation goes through a two-stage process that involves having the information reviewed by individual physicians and the results are sent in and tabulated by nine experts in a face-to-face session. Composition of the panel is very important. They need to be recognized experts, representative of practicing physicians, and recognized in academics. They need to represent both the doers and the instructors as well as the surgeons and non-surgeons. The objective is to come up with the best consensus based on the current state of practice and hopefully they will come out with a consensus.

Consensus is not always obtainable. What you do is come out with a recommendation of what is appropriate for the average patient under these conditions. Then you come out with recommendations of what is inappropriate for others. Simply stated, we don't know.

Most important in achieving guidelines should be that we come up with things that indicate when something is appropriate and very clearly indicate when something is not appropriate.

The recommendations made, most of all, must be above board and explicit and are agreed upon by recognized experts in the field.

Clearly this kind of study requires resources that are not available at the local level. Indeed the cost of doing this kind of study on one procedure can amount to as much as $300,000 to $400,000. So if we are going to do something like this, we need to do it at the national level.

There are those who think we should and those who think we shouldn't. The argument for it is relatively simple and goes somewhat as follows: When you have imperfect information it is better to use a reasoned judgement of recognized experts based on scientific data than it is for individual physicians to try to make these decisions on their own.

The most valid thing in this whole process is looking at the outcomes based on using this or similar guidelines. It should be mentioned that a good outcome is useless if a procedure should not have been done in the first place. There is an old saying that the best surgical outcome is to operate on a patient who is not very sick.

What the guidelines are supposed to do is to assist the physician by providing information in a more useful, organized, and scientific manner than he can get on his own. This should enable him to make a good judgement based upon facts and good information rather than poor information. This should tell him which procedures are likely to be effective and when they are likely to be ineffective. The final decision should be left up to the attending physician.

As we all know, the appropriateness of performing a procedure is only one factor. Other factors such as the prognosis, the individual's interest, the severity of the disease, the presence of other diseases and morbidities are such that no set of guidelines is going to tell you you must do this or do that. What it does is give you some information about how to reach that decision. On the other hand, if evidence presented indicates this procedure is ineffective, then all these other factors don't make any difference. The usefulness of this information is identifying those indications for which the procedure cannot be beneficial. If we can do that,

"Here is the definition of practice guidelines which I think is worthwhile: 'Standardized specifications for care developed by formal process which encompasses the best scientific data with expert opinion.'"

and do it well (and it looks like for 10-20% of the patients we *can* do this), it appears to be useful. We will still have good information and still treat our patients the way we think best.

Do the guidelines work? You bet they do. In 1987, the Underwriters Association of Massachusetts told the anesthesiologists of Massachusetts if they would use the ASA established guidelines for anesthesia, they would lower their professional liability rates. The outcome of this was that during 1988 there was not a single death due to an anoxic episode in the operating room when the anesthesiologists followed the guidelines.

ELECTROCARDIOGRAM OF THE MONTH

Tom Gray, D.O.
John W. Watson, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

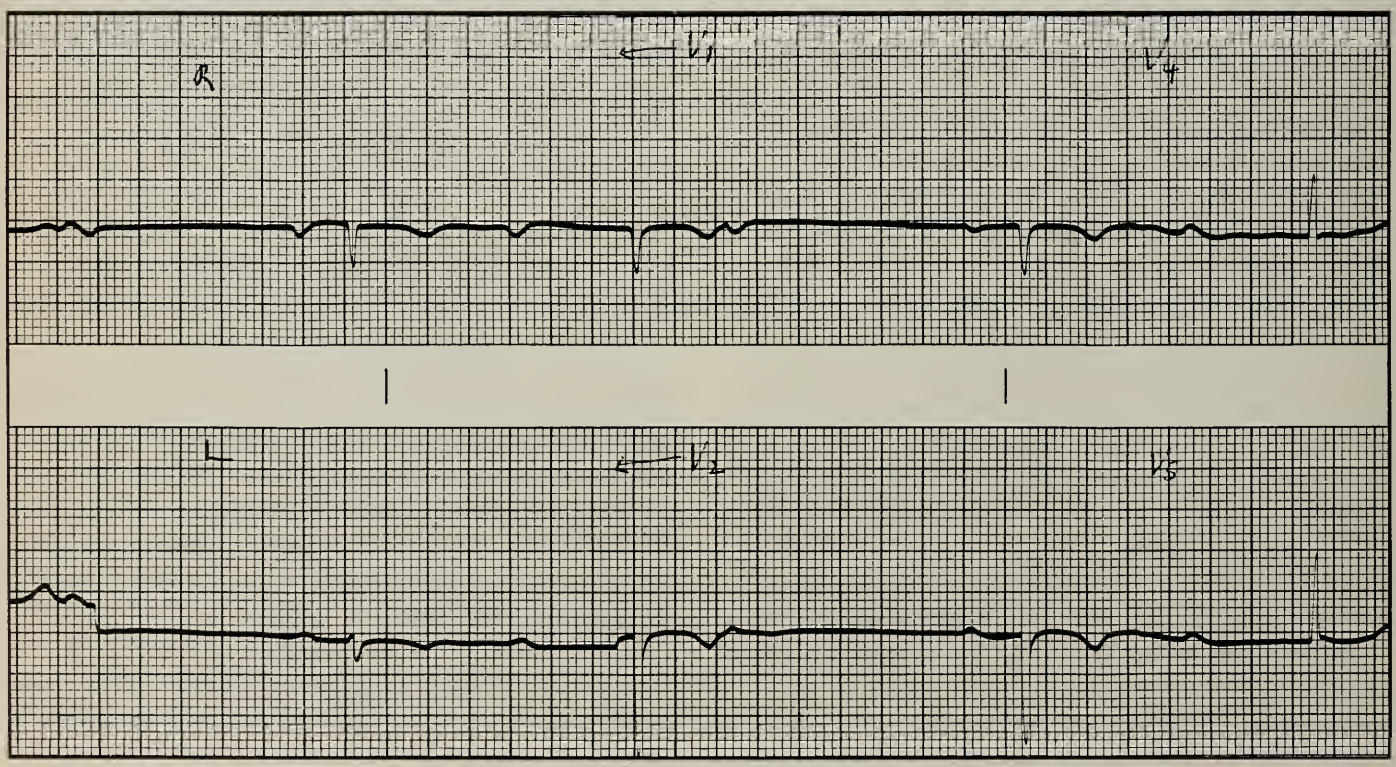
CLINICAL HISTORY:

C. M. is an asymptomatic 29-year-old man who runs marathons. His physical examination revealed a regular irregularity to his pulse and a grade 2/6 systolic ejection murmur at the base of the heart. This is his electrocardiogram. What do you think?

DISCUSSION:

The trace shows group beating with each QRS complex having a P-wave. The PR interval prolongs progressively with nonconduction of every third P-wave. The pattern is classic for 3:2 Mobitz type I AV block or "Wenckebach." Most often, it is relatively benign and is commonly associated with acute reversible states such as digoxin intoxication or inferior myocardial infarction. Type I AV block was found in 23% of endurance athletes in one study reported in 1982. The odds favor a benign explanation for both the heart block and the murmur in this young man.

The editor wishes to thank Dr. Gray of Conway for his assistance with this month's ECG.



The Harvard Resource Based Relative Value Scale

Paul Ginsburg, Ph.D.
Executive Director
Physician Payment Review Commission

Editor's Note: This article is a synopsis of Dr. Ginsburg's presentation to the Arkansas Medical Society during the annual meeting, April 27-29, 1989.

One of the largest crowds ever to gather for an AMS Annual Session program turned out to hear Dr. Ginsburg's presentation. The subject was, of course, the Physician Payment Review Commission's report to Congress on the Harvard Resource Based Relative Value Scale (HRBRVS). The Commission's final report had been presented just *one day* prior to Dr. Ginsburg's presentation to us.

After spending a few minutes explaining what forces and issues led up to the RVS study and the creation of the Physician Payment Review Commission (PPRC), Dr. Ginsburg went into the Commission's findings and recommendations.

The Commission found that the Harvard study, if modified in certain areas, could provide a sound basis for a Medicare fee schedule. Two areas require substantial modification. Better estimates are needed of the time and effort associated with pre- and post-service work (non-patient contact time). Also needed is a better way of extrapolating the relative values of non-surveyed services from surveyed services. These modifications will be made. Additionally, the Commission had determined that the way the Harvard study integrated practice cost into the RVS formula was wrong. The problem was a weak link between the valuation of a doctor's work for a particular procedure and the practice cost associated with that procedure. The effect of this error magnified the impact of the RVS, an example of which was an estimated 60% decline in revenues for Ophthalmology and Thoracic Surgery in the original study. The Commission has corrected this problem by going to an additive practice cost formula where the physician's input of work is treated separately from practice cost.

Dr. Ginsburg went on to discuss the Commission's recommendations on several other factors to be included in the proposed fee schedule. These include malpractice cost, coding reforms, geographic variations, and assignment.

Due to a variety of factors, including a desire to focus more congressional attention on the amount of money going to malpractice premiums, the Commission has recommended that malpractice cost be treated separately. This would be accomplished by identifying malpractice cost as a separate practice cost factor, or by having Medicare reimburse a portion of the premiums according to the physician's percentage of medicare patients. Either way would serve to focus additional attention on the issue.

Reforms in the coding system would focus on the standardization of global fee policies and the method of coding for evaluation and management services. The high degree of variation in the interpretation of codes, such as for a limited office visit, would be addressed by inserting "time" as a factor in the definitions of these services.

Dr. Ginsburg spent several minutes explaining the geographic variations in fees and the Commission's proposal for a "geographic multiplier." The current pattern of geographic differences appears to be less urban to rural but reflects a large variation between one urban area to another as well as one rural area to another. The Commission's proposal would get rid of the current geographic pattern by developing a "geographic multiplier" as to how payments for a procedure should vary from area to area. The multiplier would reflect the differences in non-physician practice costs but not cost-of-living figures. In this way a physician would take home the same for a particular procedure no matter where (geographically) he is located. This way was chosen because medical groups and beneficiary groups consistently indicated this was a fair way to do it. Needless to say, this will lead to big gains for rural areas.

With the development of a fee schedule, maximum allowable charge limits will no longer be appropriate for non-participating physicians. The Commission has recom-

RVS Fee Schedule Effects

Medical Specialities

Internal Medicine	Up	17%
Family Practice	Up	38%
Dermatology	Up	1%

Surgical Specialities

General Surgery	Down	10%
Thoracic Surgery	Down	20%
Ophthalmology	Down	16%
Otolaryngology	Up	6%

Hospital Based M.D.'s

Radiology	Down	21%
Pathology	Down	21%

Procedures

Office Visit	Up	28%
Total Hip Replacement	Down	17%
Coronary Artery Bypass	Down	27%
Cataract Surgery	Down	20%
X-ray of Chest	Down	16%
Electrocardiogram	Down	28%

Geographic Implications

Large Metropolitan Areas (over 5 million)	Down	14%
Large metropolitan Areas (1-5 million)	Down	3%
Small Metropolitan Areas (under 1 million)	Up	3%
Large Rural Areas (Counties over 25,000)	Up	12%
Small Rural Areas (Counties under 25,000)	Up	14%

mended, however, that the amount of balanced billing be limited by a fixed percentage over the fee schedule. The Commission also did not support mandatory assignment although four of the thirteen Commission members did file a minority opinion supporting it.

The Commission is recommending that the fee schedule be implemented over three to four years and could begin as soon as 1990. It would be done gradually and the first stage would not utilize a fee schedule but rather would move current prevailing charges in the direction of a fee schedule.

Other areas the Commission has made proposals on include spending targets as a way of setting the yearly update in the fee schedule's conversion factor. *Ideally*, the target rate of increase will be based on estimates of the increases in practice costs and enrolled beneficiaries, and a target rate of increase in volume services. The update would be based on how actual expenditures compared to the target. The Commission also has called for increased funding for effectiveness research and the development of practice guidelines.

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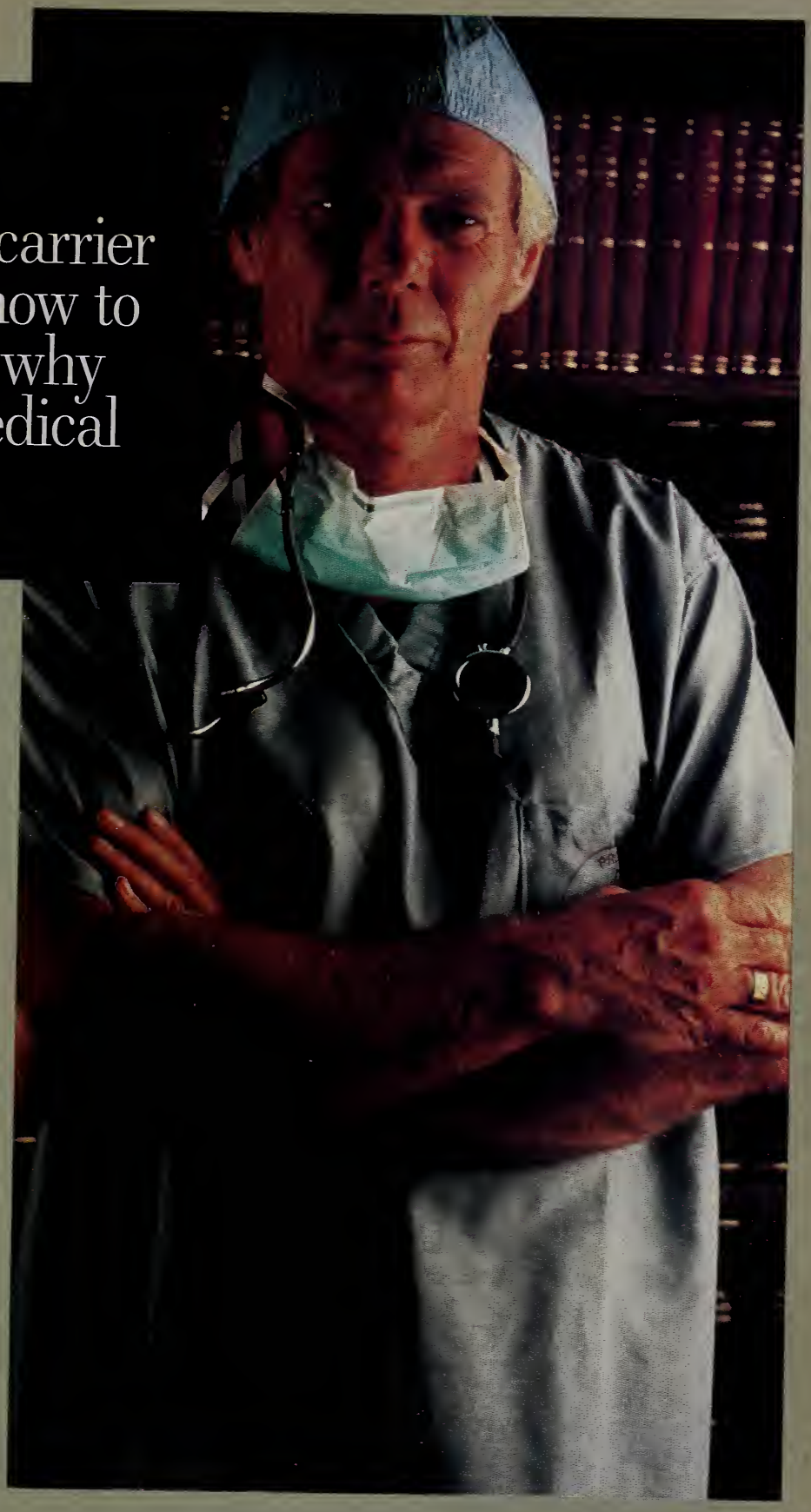


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Family Practice in an Era of Cost Containment

James R. Weber, M.D.[*]

Introduction

This presentation might be entitled "Lifestyles of a Preferred Provider." The question is "Preferred by whom?" or could be called, "Buried under an ocean of paper".

Nonetheless, I believe that the best strategy of a practicing physician today remains quality care of his patients. In family practice, this means comprehensive and continuing care of the patient and his family in a manner that is available and affordable.

I view three major components of medical care that must be balanced in any effective system. These are quality of care, availability of up-to-date services and procedures, and that these must be affordable. At present, in my opinion, we are tending to develop too much hysteria about cost at the expense of continuing high quality and keeping these services available to the people in our communities.

What is the Role of Profit in the Health Care System?

In America, wealth comes from the creation of new resources and profit is the basic driving force, the motivation behind their development and marketing. Profit is the reward for risk taking. Without the opportunity of reasonable profit, any industry in America, including health care, will stop making progress and stagnate. The potential for reasonable profit will continue to be a necessary part of the future of our health care industry. The high tech and the advances in biomedical research, the very subject of this conference, are examples of these newly developed resources.

Why would any American who wants to preserve the freedom of this great society want to remove the nation's largest service industry from the free enterprise system?

High Touch with High Tech

I applaud the progress we have made in high tech, and before we decide to slow it down or delay its application, I would like to say to you that as a practicing physician, most of the information I really need to cure the dreaded diseases of my patients has yet to be discovered.

However, we ought not to be so enamored with technology that we forget that high tech without high touch can be empty indeed.

What do I mean by High Touch?

The first basic task of a physician is to make an accurate diagnosis. This is still mainly high touch (a thorough history and physical exam), but the early diagnosis of dreaded diseases today is greatly enhanced by high tech (pap smears, blood tests, medical imaging techniques, and endoscopy, just to name a few).

The best treatment of a disease must be tailored to the individual patient and involves *high touch* entrenched in the tremendous new technology of today.

Explaining a disease process to the patient and the family in language they can understand, and educating them about the medical problem and the potential effect this will have on their lives *is purely high touch.*

Even when this is done by the most skillful physician, when the most brilliant diagnosis is made and the most sophisticated treatment is available, all is lost without the art of motivation to insure compliance on the part of the patient. This has great bearing on the success or failure of a given

[*] *President, Arkansas Medical Society, Post Office Box 188, Jacksonville, Arkansas 72076.*

Editor's Note: This article was presented in October 1988 at the Innovation Imperiled? Medical Technology in an Era of Cost Containment Conference in Chicago, IL. The conference was sponsored by the American Medical Association and The Health Policy Agenda for the American People. There is to be a follow-up conference in Washington, D.C. in September. Watch for details.

treatment. This aspect of health care occurs uniquely in the doctor-patient relationship.

I like to think that high touch in the context of high tech will be the wave of tomorrow. Activities by government or third party payors that negatively affect this unique relationship do adversely affect the quality of medical care and the outcome.

Where are We in the Cost Crisis Today?

These three to four year cycles of the private sector have been in place since the mid 1960's. The long term trend has been for the deficits to get deeper and larger and for the surplus periods to produce less reserves.

Historically, these downturns have always paralleled those in the business cycle (recession).

The downcycle this time is different. Our economy continues into the fifth year of positive business expansion (no recession). Health care is going south as if it fell off the cliff and the rest of the economy is going north. I guess that is one reason that we are all here today.

It may be true that increased utilization of modern technology and cost shifting because of low Medicare reimbursement may be two big players in this complex situation.

It is probable that the fires of cost containment have yet to be fueled to the max.

What Have We Learned From This?

For one thing, that the alternative delivery systems, HMO's, PPO's and IPA's, are just as subject to these negative underwriting cycles as traditional health insurance and to a great extent have failed as effective forces in cost containment.

The era from 1980 to 1985 stabilized cost by shifting from inpatient to outpatient care. Hospitalization utilization dropped from 900 to 450 days per 1000 subscribers today. The lines have crossed. We now pay as much for ambulatory care as hospital care.

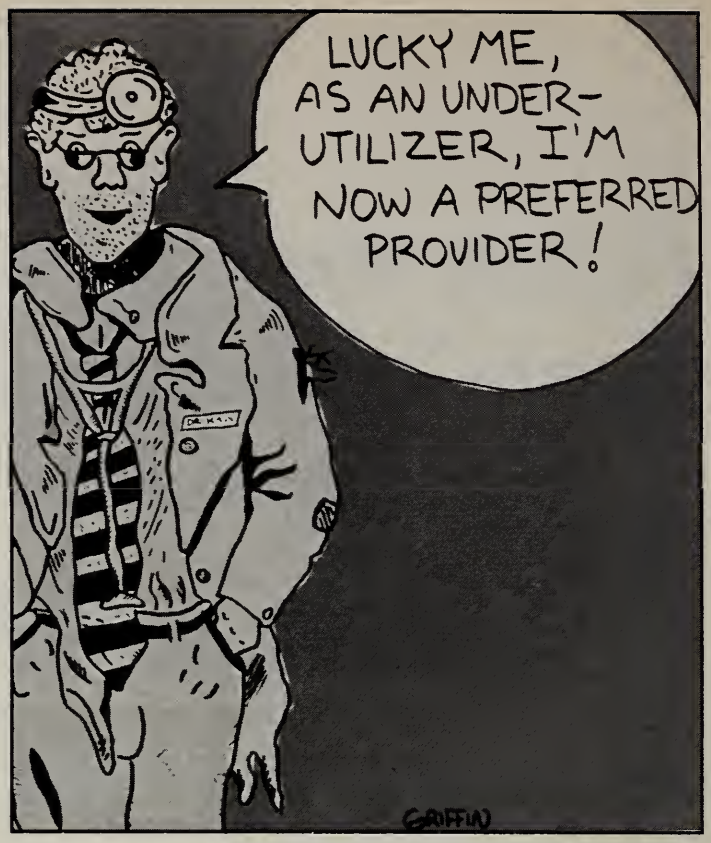
There is no new major area to focus on to reduce cost without affecting the balance between access and quality.

The employers of America can't afford this by themselves, God forbid. The providers can't absorb it by themselves. The third party payors can't afford it and the Government already has a rather substantial financial burden.

It seems clear to me that greater patient financial responsibility and participation will be reintroduced back in the system in the years ahead, most likely in the form of higher deductibles and co-pay, more limits on coverage and higher premiums. There is no other viable alternative not already in place.

Who Should Pay for Risk Management, Early Diagnosis and Prevention of Disease?

All of us recognize the great potential in this area to improve the quality of life. It is amazing that the most



dangerous things we do in America are smoke cigarettes, drive our cars without seatbelts fastened and wait for symptoms of heart attack, stroke or cancer before we go to get examined.

We all know that the health insurance contracts today basically do not cover prevention. Actuaries tell us it would probably add four to six percent to the cost of any health plan. This might even price it out of the marketplace in these competitive times. In any event, savings would not be realized for at least seven to ten or more years.

I have a suggestion to offer here. Why not consider phasing in some preventative services in the insurance plans of the future by crediting their cost to the deductible? Today, in most plans, only those services covered by the contract can apply toward the deductible.

To credit the cost of these services toward the deductible would be one way to begin to phase preventative strategies into the financing system without a great impact on cost, but still with an incentive.

Payment would be made direct by the patient and credit would be given toward the deductible, an idea for consideration yet to be tried by either the private or government sectors.

Americans have become much more interested in a healthy lifestyle today. This is reflected by the number of people who have stopped smoking and who exercise regularly. Individual patients are more willing to pay for risk management than ever before, however, health insurance programs are actually paying for more of these preventative services than we have appreciated. For example, when we consider screening for colon cancer, the number two cancer killer in our society, we realize that there are over 183

million people out there to be screened on a regular basis. We have the ability to almost eliminate this dreaded disease from society with state-of-the-art technology. Autopsy studies have shown that 40% of patients over age 50 have colon polyps and we know that cancer develops from these polyps in almost all cases. When the screening is positive, the health insurance does usually pay.

In regard to prevention of heart attack, the number one killer since the first symptom in almost 40% of cases is sudden death, we certainly do not wait for symptoms to appear today. We do risk management and treadmill stress test screening of our patients. When the tests are positive, the insurance does pay.

I believe that the widespread use of technology for early diagnosis is a bigger factor in the cost of health care today that most of us have realized. I don't think that anyone would argue that the savings of lives and the improvement of quality of life is worth the expense. The question is how to make it more affordable for the future.

Managed Care

Typically as a family physician, I am the entry for my patients into the health care system. I have a good idea how and where to get the best care available for their particular problem. I am grateful to have the sophisticated technology and consultants readily available to me and my patients. As a family physician, I probably know the system and the people better than anyone else. My family practice colleagues or I can get things done quickly and efficiently.

Today I find myself more involved in the coordination of services of consultants and subspecialists than ever before, more often managing the patient through the complexities of all aspects of the system in my community. I almost always do the initial history and physical and the discharge summary and in many instances, provide most of the total care of my patient, and in other instances work closely with consultants.

I am usually the communicator with the family for whatever team of subspecialists are on board and see the patients daily myself.

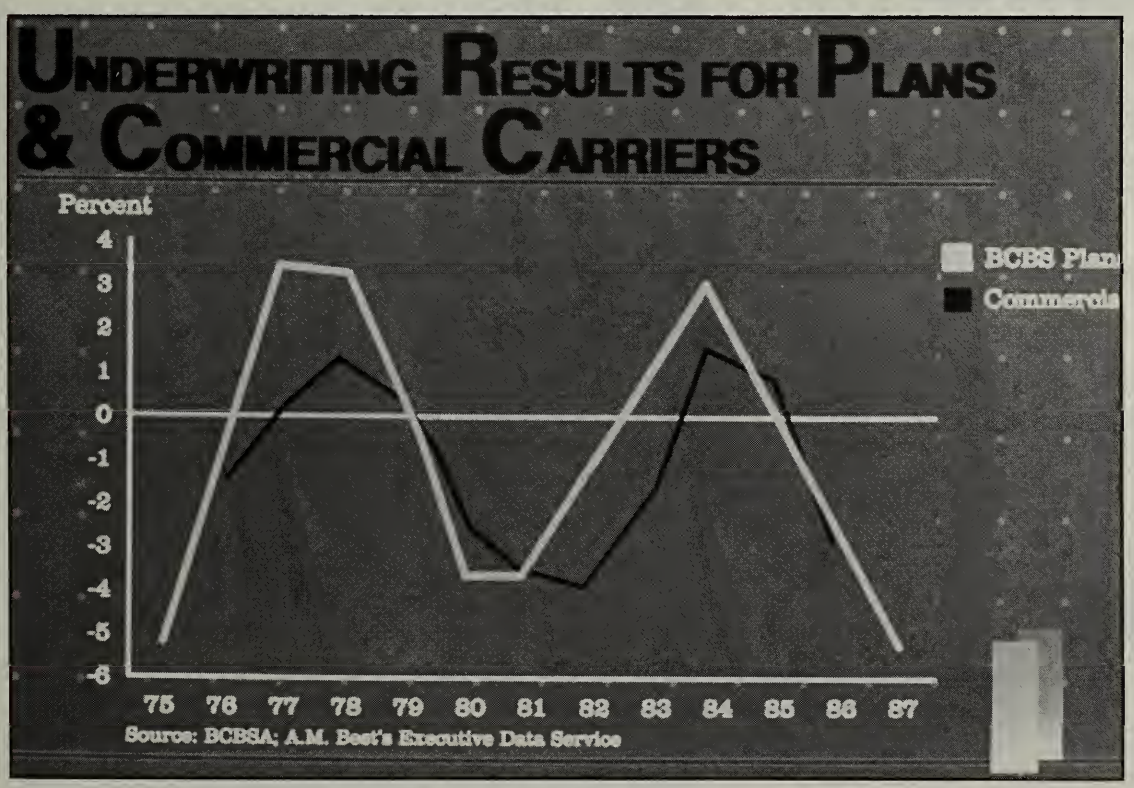
In those systems where I am the formal case manager, I have found that this does involve a great deal more time, phone calls and paperwork than I originally envisioned. I am sure that these services will be appropriately reimbursed in the future as recommended by the AMA and the American Academy of Family Physicians and that new CPT-4 codes will be developed.

I have done some consulting work in managed care and I will give a few suggestions of how the companies could improve their credibility with both physicians and patients.

When recruiting physicians, they often state or strongly imply that they have signed up the other physicians in the community when actually, they have not as yet even talked to them. Unfortunately, this first impression is often a lasting one.

Many of these companies present a "take it or leave it" contract loaded unbelievably in their favor. A solo physician or small group has difficulty negotiating. Physicians seldom forget and are non-forgiving of such strong arm tactics.

Time is a high valued possession and one of the few that is not replaceable. The techniques commonly used for Continued Stay Review of hospitalized patients is not effective. Most physicians think it is the biggest single waste of their time. This has generated almost universal hostility among physicians. As often conducted, this review provides little more than harassment to the physician who is trying to provide appropriate care to the patient.



These empty threats of denial of payment by the company occurs when the patient is often the most sick. This is very upsetting to everyone; the patient, the family and the doctor.

Experience has already shown that this activity is not cost effective and, thank God, progressive companies are changing rapidly.

Over promotion of benefits, particularly preventive services, to our patients when these are not even covered, certainly undermines credibility.

Patient confidentiality has become a major issue here. Some companies actually provide employers with a computer printout of their em-

ployees (and families) utilization and expenditures, complete by name, date of service, provider and diagnosis, ranked from the highest to the lowest utilizer. Would you want your supervisor to have this information?

Government Over Regulation

Reasonable regulations are necessary, but the high velocity winds of government over regulation in health care has become wasteful and even harmful to society.

The destruction of health services in rural America is an immediate emergency. We have spent the past 20 years working to bring well-trained physicians, modern hospitals, technology and emergency medical services to our rural communities.

The basic problem, the heart of the matter, is the low DRG payments to rural hospitals by Medicare. This must be changed.

IRS or PRO

In Arkansas, the standard intensity of review for rural physicians by the PRO is 27% and 13% for urban physicians.

It is about the same in your state. This is a by-product of the method used, a statistical aberration that needs to be repaired.

To quote our own PRO CEO, "If I were a duck flying down the Mississippi Flyway, I would rather be shot at 13 times than 27 times."

There also exists a very unfair differential in reimbursement of physician services in many rural areas of America by Medicare that needs to be changed.

The HRBRVS

For the first time, we have credible research that provides sound information on the resources involved in physician services and procedures. I think this will become an important guide for pricing in the future.

The Patient Who Falls Through All the Cracks

I envision few situations worse than being totally broke and desperately ill without access to health care. This might be comparable to being held hostage by terrorists. We can not continue to allow this to happen in America.

I would challenge my colleagues in the audience and the private sector to go back to your state society and organize a voluntary network of physicians and hospitals statewide to give the people who fall through all the cracks a personal physician and access to the medical care system. Consider patterning this after this highly successful Access to Health Care System in Kentucky or the one being developed in my home state of Arkansas by the medical society.

In 25 years of practice, my hospital has never refused when I have asked to admit an indigent patient. Not one of my colleagues has ever refused to consult or treat such patients free of charge. Physicians have done this for years with silent pride and this is commendable. I think that we are even more effective when we organize and take on the task.

I challenge the medical profession to become even more dedicated to helping these patients.

The Quality of Life is Closely Tied to Excellence in Health Care

It is for this reason and also because of the aging of the population that I believe health care in America is headed toward 15% of the Gross National Product by the end of the century.

It has been a great honor to address such a distinguished audience. Thank you.

DOCTOR...

Here's what your colleagues had to say about the 1989 Annual Meeting of the Arkansas Medical Society:

"Best AMS meeting I have ever attended! I expect the next ten meetings to eclipse 1989!"

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May 2-6, 1990
Arlington Hotel and Convention Center
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It's called talking. If your older patients don't ask you about the prescriptions they've been given, make it a point to tell them what they need to know. Make sure they know the medicine's name, how and when to take it, precautions, and possible side effects. Encourage them to write down the information and ask you questions about things they don't understand.

You'll also want to take a complete medications history including both prescription *and* non-prescription medicines. The history can alert you to the potential for drug interactions and help you simplify their regimen.

Re-introduce the oldest advance in medicines. Make talking a crucial part of your practice. Because good, clear communication about medicines isn't a thing of the past. It's the way to a healthier future.

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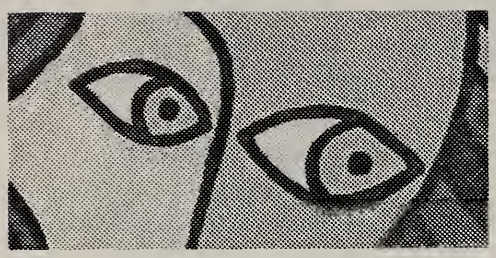
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TAKE THE FIRST STEP TO RECOVERY

The Physicians' Health Committee exists for you, the physician who is struggling with drug or alcohol addiction. The committee is composed primarily of physicians who have ``been there'' and want only to help their colleagues from making the same mistakes.

The Committee members are willing to set up interventions, recommend treatment, and help with aftercare and re-entry.

The Committee is not involved in any legal, moral or punitive judgements.

ON CALL FOR YOU

Don't throw away your profession because of drugs and alcohol. Contact our Physicians' Confidential Assistance Hotline at (501) 370-8221. Only specially trained personnel will return your call. Or contact the Arkansas Medical Society office at (501) 224-8967 or 1-800-542-1058 and ask for the name of one of the Physicians' Health Committee members.

All inquiries are confidential within the Committee and no names or locations are necessary when contacting the Society office.

Hans Georg Schlumberger, B.S., M.D. 1913-1967

Clyde J. Dawe, M.D., Ph.D.[*] and Edwina Walls, M.L.S.[+]

Although his career was foreshortened by a tragic automobile accident, Dr. Hans Georg Schlumberger had, by the age of 46, done much to initiate and shape the growth of a new twig on the many-branched tree of cancer pathology.

In the tradition of minds such as John Hunter and M. U. Leblanc, Dr. Schlumberger refused to limit his interests to human diseases; rather, he chose to pursue the investigation of cancer wherever the trail led. He found that it sometimes led to the study of cancers in monkeys, parakeets, turtles, snakes, frogs, many varieties of fish, and even to cockroaches. More than a decade before his ill-fated accident, Dr. Schlumberger, together with Dr. Balduin Lucke, published a comprehensive study of tumors in fishes, amphibians, and reptiles in which it was emphasized that neoplasms occur quite commonly not only among warm-blooded mammals and birds, but also among the cold-blooded "lower" vertebrates. Nine years later he reported that naturally-occurring tumors are to be found characteristically in certain organs in certain species, either because of genetic-evolutionary predisposition, or because of the peculiar environmental influences to which the respective species are subjected. His observations in these and other papers pre-dated a wave of studies extending from 1960 to the present, in which cancers in feral lower animals have been investigated as potential indicators of environmental cancer agents, most particularly chemicals and viruses.

In 1965 the National Cancer Institute activated a Registry of Tumors in Lower Animals at the Smithsonian Institution in Washington, D.C. At that time, Dr. Schlumberger had been lying in coma for some 6 years following his accident, but his hand was plainly visible in the processes leading to the founding of the Registry, through the revealing investigations he had conducted and published in the 20 years from 1939 to 1959. The many specimens Dr. Schlumberger had collected and analyzed during those years are housed in the Smithsonian Registry which now encompasses the largest collection of tumors in lower animals in the world and includes in its files a complete catalogue of the world literature on such tumors.

While Dr. Schlumberger was a pioneer in comparative oncology, this facet of his works developed secondarily from his activities as a practitioner, researcher, and teacher in medical pathology. Born in Hamburg, Germany in 1913, he came to the United States at the age of 3 with his parents and spent his earlier years in Milwaukee. He took a B. S. degree from the University of North Carolina and the M.D. degree from the University of Pennsylvania. During his residency training in pathology, he came under the influence of Dr. Balduin Lucke, a pathologist who was first to discover evidence that kidney cancers in leopard frogs are caused by a virus now known to be a member of the herpesvirus group. Schlumberger's collaborative studies with Lucke concerned with the frog tumors, were interrupted by World War II,



[*] *Research Associate, Department of Pathology, Harvard Medical School, Boston, MA.*

[+] *University of Arkansas for Medical Sciences, Medical Library, Archives Division, 4301 West Markham, Little Rock, Arkansas 72205.*

during which he distinguished himself as a pathologist in the Army Medical Corps, achieving the rank of Lieutenant Colonel. After the war, Dr. Schlumberger resumed his investigations of the frog kidney tumors, but continued to serve the Armed Forces Institute of Pathology in Washington as a civilian consultant. During the post-war period his interests in cancers in lower animals began to burn anew, and he soon gained an international reputation for his broad, unequalled knowledge in that field. He held faculty appointments in the pathology departments at the University of Pennsylvania, Western Reserve University, and Ohio State University before becoming chairman of the pathology department at the University of Arkansas Medical Center in 1957. He was affiliated with the major societies for experimental and clinical pathology, was elected to Phi Beta Kappa and Sigma Xi, and served on the Pathology Study Section of the National Institute of Health. In 1970 a cover story in *Cancer Research* recognized his outstanding contributions to the field of comparative oncology.

This commentary would not be complete without a word on Hans Schlumberger, the person. Hans was a warm, vital man with boundless energies and infectious enthusiasms. His sense of humor was finely honed on the stone of insight into his own image, and this enabled him to become theatrically entertaining in presenting scientific papers that could have been banal in other hands. In his German accent, (deliberately exaggerated, one suspects) he would simultaneously describe and mimic the wing movements of a parakeet afflicted with a brain tumor, sharpening the image by flashing a profile of his aquiline nose. He took his work with lower animals seriously, but never too seriously, and knew how to express this attitude tongue-in-cheek. Once, when called by a surgeon to make an immediate frozen-section diagnosis of a biopsy from a patient on the operating table, Hans replied: "But that's impossible! I'm right in the middle of an autopsy on a cockroach." Another anecdote related that during a countryside picnic he lost potential favor with a comely young lady by becoming engrossed in catching goldfish from a nearby pond. He had had the bad luck to notice that some of the fish bore skin tumors, which were to become the subject of some of this subsequent papers.

As a teacher, Hans was successful partly because of his thorough knowledge of his topics, but partly because of his stimulating personality. Medical students are not renowned for their acceptance of professional patronage, and pathologists are not renowned for their popularity among medical students, but graduating classes at Ohio State University and the University of Arkansas chose Hans as their "Man of the Year" in 1955 and 1959.

On April 6, 1967, after more than seven years in coma, Hans died. His years of professional activity were relatively few, but they were intense, productive, and influential. Where he was once almost alone, there are now many engaged in the search he began.

Editor's Note: Dr. Schlumberger became Chairman of Pathology at the University of Arkansas for Medical Sciences July 1, 1957. He suffered a severe head injury April 14, 1960, in an auto accident in Little Rock and was in a coma for seven years, dying April 6, 1967. His marvelous collection of books on comparative pathology and history of the sciences comprises the Schlumberger Collection and resides in the History of Medicine Room in the Library of the University of Arkansas for Medical Sciences. It is from this collection that Dr. Dawe's article was taken.

DOCTOR...

Listen to your colleagues' praise of the 1989 Annual Meeting of the Arkansas Medical Society:

"Timely program, organized, up-beat and well-done"

Don't miss the 1990 Annual Meeting of the Arkansas Medical Society
May 2-6, 1990
Arlington Hotel and Convention Center
Hot Springs

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THINGS TO COME

JULY 20

Symposium on Asthma. Sponsored by Washington University School of Medicine. Presented by Phillip E. Korenblat, M.D. Washington University Medical Center, St. Louis, MO. 8.5 Category I credit hours. Fee: $35.00. Further information, Cathy Caruso, Washington University Medical Center, 660 South Euclid, Box 8063, St. Louis, MO 63110; 1 (800) 325-9862.

JULY 29

Sports Medicine Symposium. Sponsored by the Baptist Medical Center. Presented by Michael Bailey, Bob Goldman, D.O., Laura Hensley, Karen Massingale-Ewan, Mike Newell, Richard A. Nix, M.D., Katherine Riley-Shoulders, M.S., and Tom Roberts, M.D. J. A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. Category I credits: 6.25; contact hours for nurses, 6.25; and pharmacy continuing education credit. Fees: (before July 14) $75, physicians and $30, coaches, trainers, athletes and others; after July 14, $90, physicians; $40, coaches, trainers, athletes and others. Further information, Baptist Medical Center, Medical Education Department, (501) 227-2672.

JULY 23-28

Physicians and Their Families. Sponsored by the Menninger Clinic. Presented by Roy W. Menninger, M.D. and Bev Menninger; Becquer Benalcazar, M.D., and Regine Benalcazar-Schmid, M.D.; Glen O. Gabbard, M.D., and Joyce Davidson Gabbard, M.D.; Joseph Hyland, M.D., and Patricia Spiegelberg Hyland, M.D.; and Martin B. Leichtman, Ph.D. and Maria Louisa Leichtman, Ph.D. Grande Butte Hotel, Crested Butte, Colorado. Fee: $595 per couple. Deadline for registration June 30, 1989. 22.5 Category I credit hours. Further information, Jayne Roberts, Division of Continuing Education, The Menninger Clinic, Box 829, Topeka, KS 66601-0829; 1 (800) 288-7377, ext. 5994.

SEPTEMBER 18-21

41st AAFP Annual Scientific Assembly. Sponsored and presented by AAFP. Los Angeles Convention Center. Category I credit availabe. For complete information contact: Beth Paulsen, AAFP at 1 (800)-274-2237.

SEPTEMBER 27-29

Women and Self Esteem: Exploring the Forces that Enhance and Diminish the Self. Sponsored by the Menniger Clinic. Ramada Inn Tower Plaza, Topeka, KS. Nineteen Category I credit hours; 18.45 hours for social workers; and 19 contact hours for nurses. Fees: $235 per person. For further information, contact: Jayne Roberts, Conference Coordinator, The Menninger Clinic, 1 (800) 288-7377.

KEEPING UP

Cholesterol: Current Concepts for Physicians

Self-Study Course for Physicians. Sponsored by the National Heart, Lung and Blood Institute. A national cholesterol education program is available through the Arkansas Medical Society office in which a physician studies at home. Two Category I credit hours. Further information: David Wroten, Arkansas Medical Society, Post Office Box 5776, Little Rock, AR 72215; (501) 224-8967.

Out of Control Teenagers

July 21, 12:30 p.m. Presented by Toni Loftin, M.S. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Tumor Conference

July 25, 12:00 noon. Presented by W. J. Burt, M.D. Sponsored by AHEC Fort Smith. Fourth Floor Conference Room, Sparks Regional Medical Center.

Sports Medicine Symposium

July, 29. Sponsored by Baptist Medical Center. J. A. Gilbreath Conference Center. For further information, contact the Baptist Medical Center.

CME Dinner Seminar for Medical/Dental Staff

August 1, 6:30 p.m. - 8:00 p.m. Presented by Bob Goldman, "Anabolic Steroids and Drug Use in Sports."

Sponsored by AMI National Park Medical Center. AMI National Park Medical Center - Ozark/Quapaw Room.

Hypergylcemia and Complications

August 3, 12:00 noon. Presented by Ron Robinson, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Attention Deficit Hyperactivity Disorder

August 17, 8:00 a.m. Second Annual Conference on the Child and the Community. Presented by Richard Livingston, M.D.; Samuel D. Clements, Ph.D; Shelvie Cole, Mike Moss, Robert Hughes, M.D.; John Sadley, M.D., Inmates from Tucker Unit. Sponsored by AHEC Fort Smith. Breedlove Auditorium, Westark Community College. Seven Category I credit hours pending. Fee: $15.00 (includes lunch).

Family Therapy

September 15, 12:30 p.m. Presented by Fred Hagemeier, Ed.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

AR Academy of Ophthalmology Annual Meeting

September 22 & 23, 7:30 a.m. Presented by Robert Reinecke, M.D., Philadelphia; and Barry Leader, M.D., New Orleans. Lake Hamilton Resort, Hot Springs. Eight Category I credit hours. Fee: $50.00.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Tuesday or Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, Sturgis Building, Room 121
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Second Floor Classroom
Pediatric Research Conference, third Monday, 12:00 noon, Sturgis Building, Rooms S120-121
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Cancer Conference, first Wednesday, 12:00 noon, CARTI Auditorium. A meal is provided.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell Room. A meal is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. A meal is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Arkla Room. Refreshments are provided.
Internal Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. A meal is provided.
Pediatric Conference, first Tuesday, 12:30 p.m., LaHarpe de Paul Room. A meal is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
GI Conference, third Thursday, 12:00 noon, Conference Room 1.
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, fourth Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS Education Building, Room G137, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B.
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH.
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33.
Ob/Gyn Grand Rounds, Wednesdays, 7:30 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Fundamental Sciences Conference, first Tuesday, 6:00 p.m., UAMS Chancellor's Area, Conference Room B-2
Surgery Grand Rounds, one Saturday per month, 8:00 a.m., UAMS Education Building, Room G/141A, 1.5 credit hours
Surgery Morbidity and Mortality Conference, Wednesdays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Resident Case Conference, Mondays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Review Conference, Mondays, 6:00 p.m., UAMS Education Building, Room G/141A
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Conference (Pediatric), once monthly, 5:00 p.m., Arkansas Children's Hospital, Sturgis Building, Clinic 2
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Tuesdays, 5:00 p.m., UAMS Education Building, Room G/131A&B

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:15 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:15 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:15 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:15 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:15 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:15 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:15 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
Family Medicine Conference, eacg Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tueaday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village.
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff.
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

Technical Exhibitors...

Here's what your colleagues had to say about the 1989 Annual Meeting of the Arkansas Medical Society:

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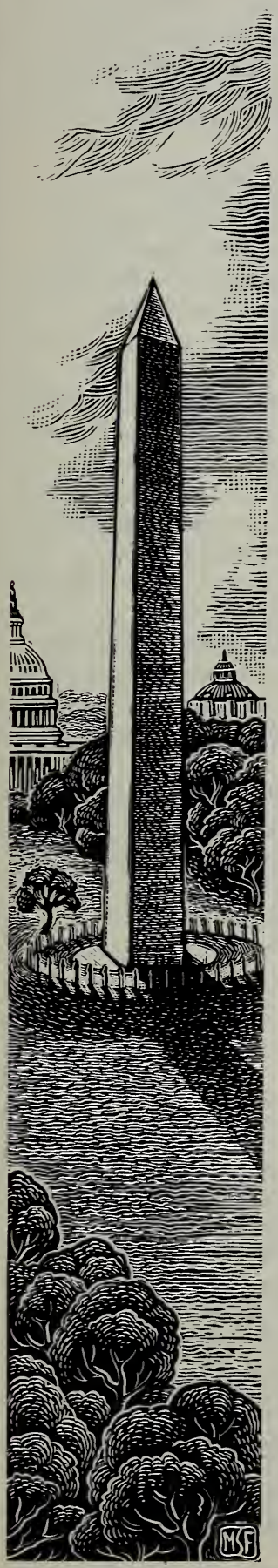
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AMS NewsMakers

H. A. Ted Bailey, Jr., M.D., a Little Rock otologist, has been elected 1989-90 national president of the American Otological Society.

Glen Schoettle, M.D., a West Memphis general surgeon, recently received a plaque of apreciation for his efforts at Crittenden Memorial Hospital's chief of staff. The plaque was awarded to Dr. Schoettle at a CHM Board of Trustees meeting.

James G. Kinley, M.D., has been promoted to the rank of lieutenant colonel in Headquarters Battery 2nd Battalion 142nd Field Artillery at Fort Smith, Army National Guard. Dr. Kinley is a family practitioner in Beebe.

Ron Boyle, M.D., a Little Rock psychiatrist, has been selected as the new director of community liaison services for The Bridgeway Hospital.

A Conway physician recently received the Counseling Associates, Inc., Mental Health Award at the group's awards banquet. **Phil Stone, M.D.**, an emergency room physician, received the award for his help with the Help for Abuse Victims in Emergency Need(HAVEN) program. Dr. Stone donates his time for house calls and physicals for HAVEN residents as well as serves on the Faulkner County Child Protection Team.

C. Mack Shotts, M.D., a family practitioner from Paragould, was been elected to the Board of Directors of the Security Bank of Paragould.

John Lange, M.D., was the speaker at the 115th national meeting of the American Association for the Advancement of Sciences. Lange, a urologist with Holt-Krock Clinic in Fort Smith, spoke about the topic, "AIDS, Social Genesis and Ethical Revolution."

A Helena physician was honored by the Helena-West Helena School District recently. **Robert Miller, M.D.**, a family practitioner in Helena, received a plaque for his contribution to the special education children of the area. Dr. Miller served as grand marshall of the opening ceremonies for the Olympic Fun Day.

Little Rock neurosurgeon **Steven L. Cathey, M.D.** has been selected as the 28th Distinguished Alumnus at the University of Arkansas at Monticello.

Benjamin N. Saltzman, M.D., a Little Rock family practitioner and members of the editorial board of the *Journal of the Arkansas Medical Society*, has been chosen to receive an honorary doctor of science degree from the University of Arkansas for Medical Sciences. Saltzman was awarded the degree for his service as the director of the State Department of Health as well as his contributions to the rural medical development programs.

Ted E. Ashcraft, a Russellville family practitioner, recently attended the 20th Annual Medical Scientific Confer on Alcoholism and other Drug Dependences in Atlanta, GA. Dr. Ashcraft is a diplomate of the AAFP and certified by the American Medical Society on alcoholism and other drug dependences (AMSAODD).

New Members

BENTON COUNTY MEDICAL SOCIETY

Stinnett, Scott G., Family Practice, Siloam Springs. Born, November 22, 1959, Little Rock. Pre-medical education, Duke University, A.B., 1982. Medical education, University of Arkansas for Medical Sciences, 1986. Residency, University of Oklahoma, Tulsa Medical College. Member, AAFP.

Summerlin, William T., Allergy and Dermatology, Rogers. Born December 6, 1938, Anderson, SC. Pre-medical education, Emory University, Atlanta, GA, B.A., 1960. Medical education, Emory University, 1964. Internship, John Sealy Hospital, University of Texas, Galveston. Residency, Stanford University Department of Dermatology, Palo Alto, CA. Military record, U.S., Army, Captain, Brooke Army Medical Center, 1965-67. Teaching Appointments, Instructor, Dermatology, Stanford University; Assistant Professor, Department of Dermatology, Stanford University. Other appointments, Terrebonne Parish General Hospital, Board of Commissioners; Medical Director, Houma Medical & Surgical Clinic. Practice experience, 12 years, Houma, Louisiana. Board certified, Dermatology; Allergy & Immunology. Member, American Academy of Dermatology, American College of Allergists; American Board Dermapathology.

BOONE COUNTY MEDICAL SOCIETY

Miller, Jr., Robert L., Pathology, Anatomical and Clinical. Born June 28, 1951, St. Petersburg, FL. Pre-medical education, Massachusetts Institute of Technology, B.S., 1973. Medical education, Emory University School of Medicine, M.D., Ph.D., 1979. Internship/residency, Emory University Affiliated Hospitals. Practice experience, 6 years, North Arkansas Medical Center. Board certified, Pathology. Member, Sigma XI, ASCP, IAP, AAAS, AMA, AFP.

CRAIGHEAD-POINSETT MEDICAL SOCIETY

Anderson, Charles B, Neurology, Jonesboro. Born April 6, 1947, Minneapolis, MN. Pre-medical education, Dartmouth College, Hanover, NH, A.B., 1969. Medical education, Dartmouth Medical School, B.M.Sc.; University of Minnesota, M.D., 1972. Internship, Manuel Hospital, Portland, OR. Residency, University of Minnesota Affiliated Hospitals. Practice experience, 11+ years, Fargo, ND. Teaching appointments, Assistant Clinical Professor of Neurology, University of North Dakota Medical School. Board certified, Psychology and Neurology. Member, American Academy of Neurology, Minnesota Society of Neurological Sciences.

MILLER COUNTY MEDICAL SOCIETY

Hurley, James M., Cardiology, Texarkana, TX. Born September 18, 1951, Magnolia. Pre-medical education, Southern State, 1973. Medical education, University of Arkansas for Medical Sciences, 1978. Internship, UAMS. Residency, UAMS (IM); Louisiana State University (Cardiology). Practice experience, 8 years, Southern Clinic; 1 year, Texarkana Cardiology Associates. Board certified, Internal Medicine and Cardiology.

Lee, Allen R., Cardiology, Texarkana, TX. Born November 22, 1945, Hot Springs. Medical education, University of Arkansas for Medical Sciences, 1971. Residency, UAMS. Practice experience, 13 years, Southern Clinic; 1 year, Texarkana Cardiology Associates.

MISSISSIPPI COUNTY MEDICAL SOCIETY

Hester, Karen S. C., Pediatrics, Blytheville. Born January 28, 1958, Batesville. Pre-medical education, Arkansas College, B.A., 1980. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, Arkansas Children's Hospital. Board eligible. Member, AAP.

Hester, Richard L., Internal Medicine, Blytheville. Born February 7, 1959, Pine Bluff. Pre-medical education, Hendrix College, B.A., 1981. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, University Hospital. Board certified, Internal Medicine. Member, AMA.

PULASKI COUNTY MEDICAL SOCIETY

Heard, Jeanne K., General Internal Medicine, Little Rock. Born April 16, 1949, Long Beach, CA. Pre-medical education, University of Arkansas, Fayetteville, B.A., 1971. Medical education, University of Arkansas for Medical Sciences, Ph.D, 1981; M.D., 1985. Internship/residency, UAMS. Practice experience, 1 year, John McClellan VA Hospital, Little Rock. Board certified, Internal Medicine.

SALINE COUNTY MEDICAL SOCIETY

Smith, Robert E., Diagnostic Radiology, Benton. Born June 27, 1956, Little Rock. Pre-medical education, University of Texas, Austin, B.S.ChE, 1978. Medical education, Southwestern Medical School, Dallas, 1982. Internship, Tulane University Affiliated Hospitals, 1983. Residency, Michigan State University. Practice experience, 2 years, interventional radiology and imaging fellowship, UAMS. Board certified, ABR. Member, ACR, RSNA, ARRS, AMA.

Taylor, Dan W., General Surgery, Benton. Born February 17, 1937, Shawnee, OK. Pre-medical education, Oklahoma State University, B.S., 1959. Medical education, University of Oklahoma, Oklahoma City, 1963. Internship/residency, Oklahoma University Health Sciences Center. Military record, U.S. Air Force, 1968-70. Practice experience, 5 years, Stillwater, OK; 11 years, Oklahoma City, OK; 2 years, Medical Director, Blue Cross Blue Shield. Board certified, Surgery.

SEBASTIAN COUNTY MEDICAL SOCIETY

Stillwell, Mark L., Infectious Diseases and Internal Medicine, Fort Smith. Born January 16, 1956, Liberal, KS. Pre-medical education, University of Oklahoma, B.S., 1978. medical education, University of Maryland, 1982. Internship/residency, University of Maryland. Teaching appointments, Instructor, Internal Medicine, University of Maryland. Board certified, Internal Medicine. Member, AMA, ACP, Alpha Omega Alpha, Medical and Chiruigical Faculty of the State of Maryland.

TRI-COUNTY MEDICAL SOCIETY

Kearns, Harry J., Radiology, Hardy. Born February 18, 1933, Shattuck, OK. Pre-medical education, University of Oklahoma. Medical education, University of Oklahoma School of Medicine, 1957. Internship/residency, St. Anthony Hospital, Oklahoma City, OK. Military record, U.S. Army, 3 years. Practice experience, 19 years, St. Anthony Hospital, Staff Radiologist; 3 years, Holdenville General Hospital, Holdenville, OK; 2 years, Baptist Memorial Hospital, Hardy. Teaching appointments, Clinical Instructor, Radiology, Oklahoma University Health Center. Board certified. Member, ACR, RSNA, SNM.

Pickens, Jeffrey S., Family Practice, Hardy. Born January 15, 1955, Evansville, IN. Pre-medical education,

Abilene Christian University, B.A., 1977. Medical education, University of Texas Medical Branch, 1981. Residency, Baptist Hospital, Gadston, AL. Practice experience, 2 years, Hardy; 1 year, San Antonio; 1 year, Bryan, TX; 2 years, Hearne, TX. Board certified, Family Practice. Member, American Academy of Family Physicians.

WASHINGTON COUNTY MEDICAL SOCIETY

Ortego, Terryl J., Gastroenterology, Springdale. Bborn September 9, 1956, Shreveport, LA. Pre-medical education, University of Southwestern Louisiana, B.S., 1977. Medical education, Louisiana State University, New Orleans, 1981. Internship/residency, University of Arkansas for Medical Sciences. Practice experience, 2+ years, Ochsner Clinic, Baton Rouge; 3 months, NWA Gastroenterology Clinic, Springdale. Other positions, Chief of Gastroenterology, Ochsner Clinic, Baton Rouge. Board certified, Internal Medicine; Gastroenterology. Member, AMA, AGA, American College of Gastroenterology.

RESIDENT PHYSICIAN SECTION

Bennett, Charles J., Radiology/Oncology. Born January 22, 1961, Wilmot, AR. Pre-medical education, University of Arkansas at Monticello, B.S., 1983. Medical education, University of Arkansas for Medical Sciences, 1989. Internship, UAMS. Residency, University of Florida, Gainesville.

Mosley, David H. Born June 22, 1962, El Dorado. Pre-medical education, Ouachita Baptist University, Arkadelphia, B.S., 1984. Medical education, University of Arkansas for Medical Sciences, 1989. Internship, UAMS AHEC - Fort Smith.

Pope, David N., Dermatology. Born September 2, 1961, Little Rock. Pre-medical education, Ouachita Baptist University, Arkadelphia, B.S, 1984. Medical education, University of Arkansas for Medical Sciences, 1989. Internship, UAMS.

Young, Karen L., Psychiatry. Born June 21, Jacksonville, IL. Pre-medical education, Harding University and University of Central Arkansas, M.S., 1983. Medical education, University of Arkansas for Medical Sciences, 1989. Residency/internship, UAMS.

In Memoriam

DR. VERNON CARTER, JR., M.D.

Dr. Vernon Carter, Jr., M.D., a retired Benton dermatologist, died May 23 in Auburn, AL. He was 60.

Dr. Carter was president and founder of the Space Dermatology Foundation and a former board member of the North American Clinical Dermatology Society.

He was a member of the Arkansas Medical Society and the AMA. Dr. Carter was the president of the Forrester Historical Society as well as past president of the Northwest Arkansas Cattleman's Association.

During the Korean War, Dr. Carter flew over 100 missions with the Air Force.

Survivors include two sons, Robert S. Carter of Little Rock, and Lt. Kenneth Carter, a U. S. Air Force serviceman stationed in West Germany; and two daughters, Barbara C. Perry of West Palm Beach, FL, and Cynthia C. Jones of Edgewater, FL; and three grandchildren.

Memorials honoring Arkansas Medical Society members and their families can be made to the Medical Education Foundation for Arkansas (MEFFA), Post Office Box 5776, Little Rock, Arkansas 72215.



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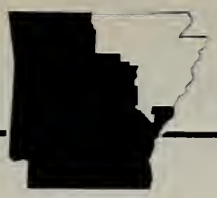
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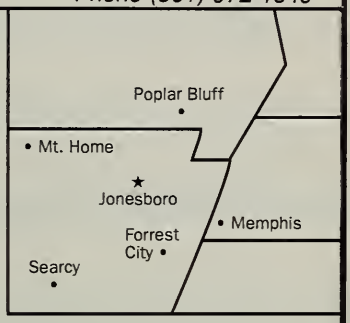
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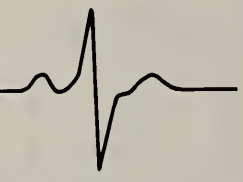
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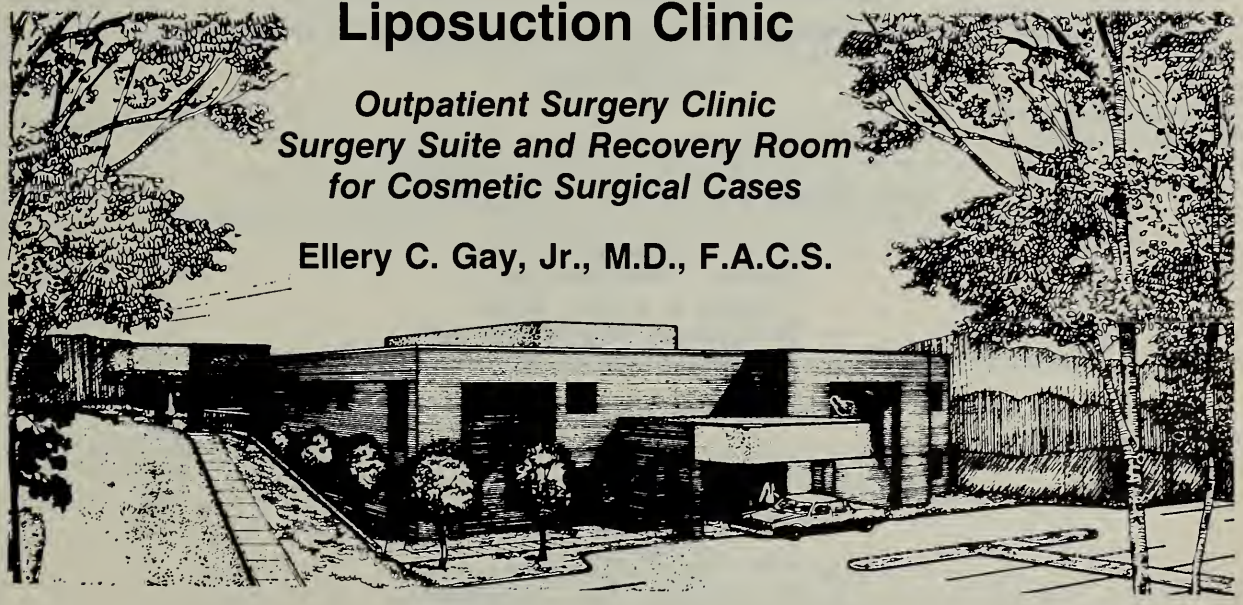
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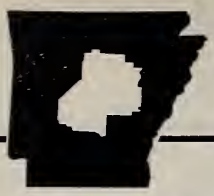
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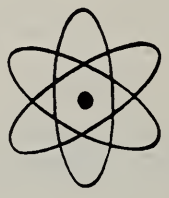
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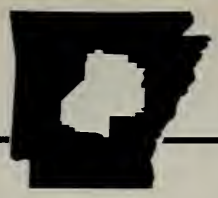
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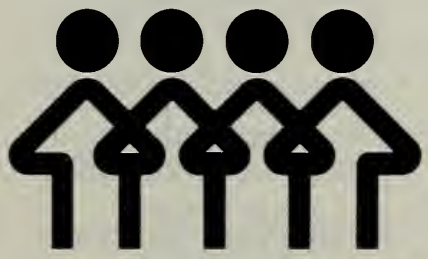
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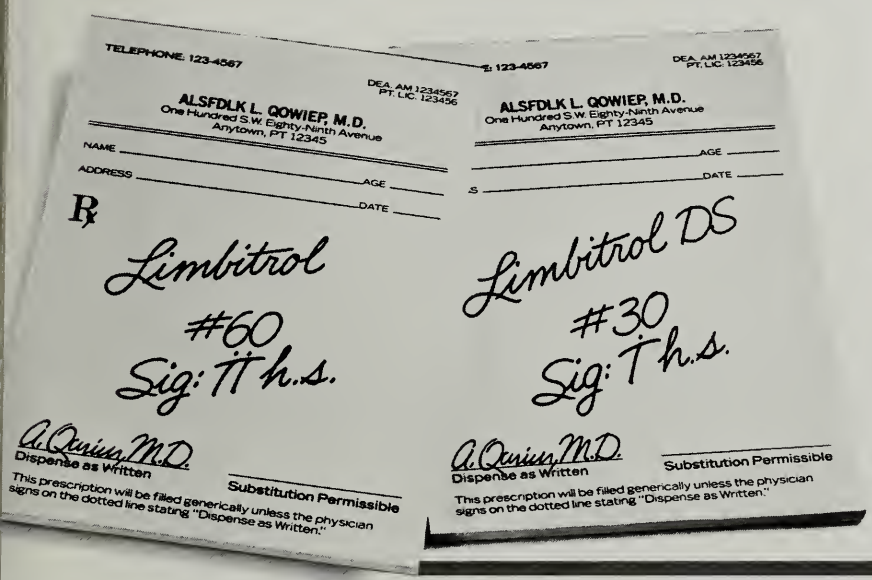
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***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

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Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

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Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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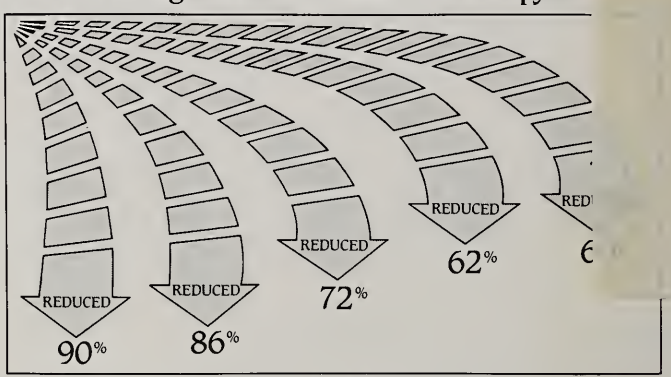
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On Our Cover: The photo of the summer sunset on the Arkansas River was taken by Jeff D. Angel, M.D., an orthopedic surgery resident. Dr. Angel used a Nikon N-2000 with Kodak VRG ASA 200 film.

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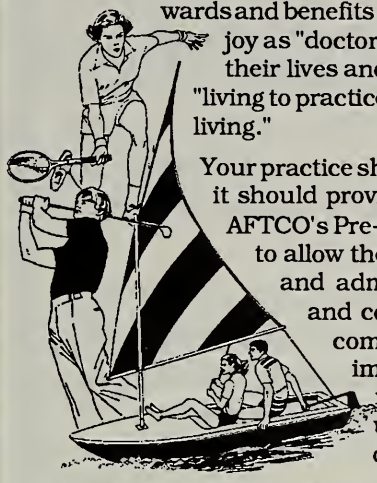
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Special Education in Arkansas

E. W. Ashcraft, M.D., F.A.A.P. and Tom Nosal, M.C.S.W., A.C.S.W.*

Editor's Note: *The Journal will be presenting a three-part series on special education in Arkansas and its implications for the medical comminity. This article is the first in the series and will be followed by "Problems Relative to Special Education in Arkansas" in next month's issue. The final segment, "Early Intervention Services for Developmentally Delayed Infants and Toddlers in Arkansas", will appear in the October 1989 issue of the Journal.*

Introduction

Over the years, there has been a dramatic increase in the number of children who require special education and health related services in the public schools. Primary care physicians need to have a general working knowledge of the special education system in public schools, how to access this system for their patients, along with an understanding of some of the inherent problems in providing special education services for children with handicapping conditions and other health related problems.

The state of Arkansas recognizes eleven handicapping conditions that require special education placement. They are: 1) hearing impaired (deaf and hard of hearing); 2) visual handicapped, 3) severe/profoundly handicapped, 4) mental retardation, 5) multi-handicapped, 6) other health impaired (to include autism and chronic medical diseases), 7) orthopedically impaired, 8) specific learning disability, 9) seriously emotionally disturbed, 10) speech impaired, and 11) deaf blind.

For the 1976-1977 academic year, 3,708,588 children between the ages of three to 21 years were served by handicapping condition criteria. In 1988, 4,421,601 children are now served in this country.[1] In the state of Arkansas, 44,587 children were served as of December 1, 1987.[2] The specific breakdown of these handicapping conditions are listed in in Table I.

In Arkansas, the mechanism for providing special education services for any child (no matter what the handicapping condition) is governed by the general outlines as established under the State Plan for Special Education to implement Act 102 of 1973, as amended by Act 641 of 1975, the Handicapped Children's Act, and Public Law 94-142, the Education for all Handicapped Children Act of 1975.[3] The basic components of this process include child find, referral, evaluation, program planning, placement, and annual review. A flow chart for the placement procedures is outlined in Table II.[4]

Child Find

The law requires that the local school district must make every effort to locate and identify all children who may be handicapped, to include all children served and unserved. This can be done through 1) routine screening procedures of all children with physical, behavioral, and educational problems, 2) formal or informal screening of children upon entering kindergarten or the first grade, 3) screening children who transfer into a new school district, 4) screening periodically throughout the child's academic career, or 5) screening of preschool children with handicapping conditions (under Public Law 99-457). Parental permission is required when only one child is singled out or tests are to be administered to that child alone.

A public awareness campaign must be undertaken to inform the community about the right to and the availability

Table I. Handicapped Children being Served in Arkansas

	Grand Total	State %	National %
MR	11,573	26.8	15.0
HOH	296	7.0	*1.5
DEAF	108	3.0	
SI	8,339	19.3	25.8
VH	108	3.0	0.61
SED	411	10.0	8.7
OI	161	4.0	1.3
OHI	199	5.0	1.2
SLD	22,845	53.0	43.6
DB	4		0.04
MH	543	13.0	2.2

* *National Percentage for Hard of Hearing is a combination of HOH and Deaf.*

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of educational services for handicapping conditions. The schools are required to maintain records of all available awareness activities, to annually review records of children receiving special education services, and to cooperate/coordinate in all district screening and location efforts.

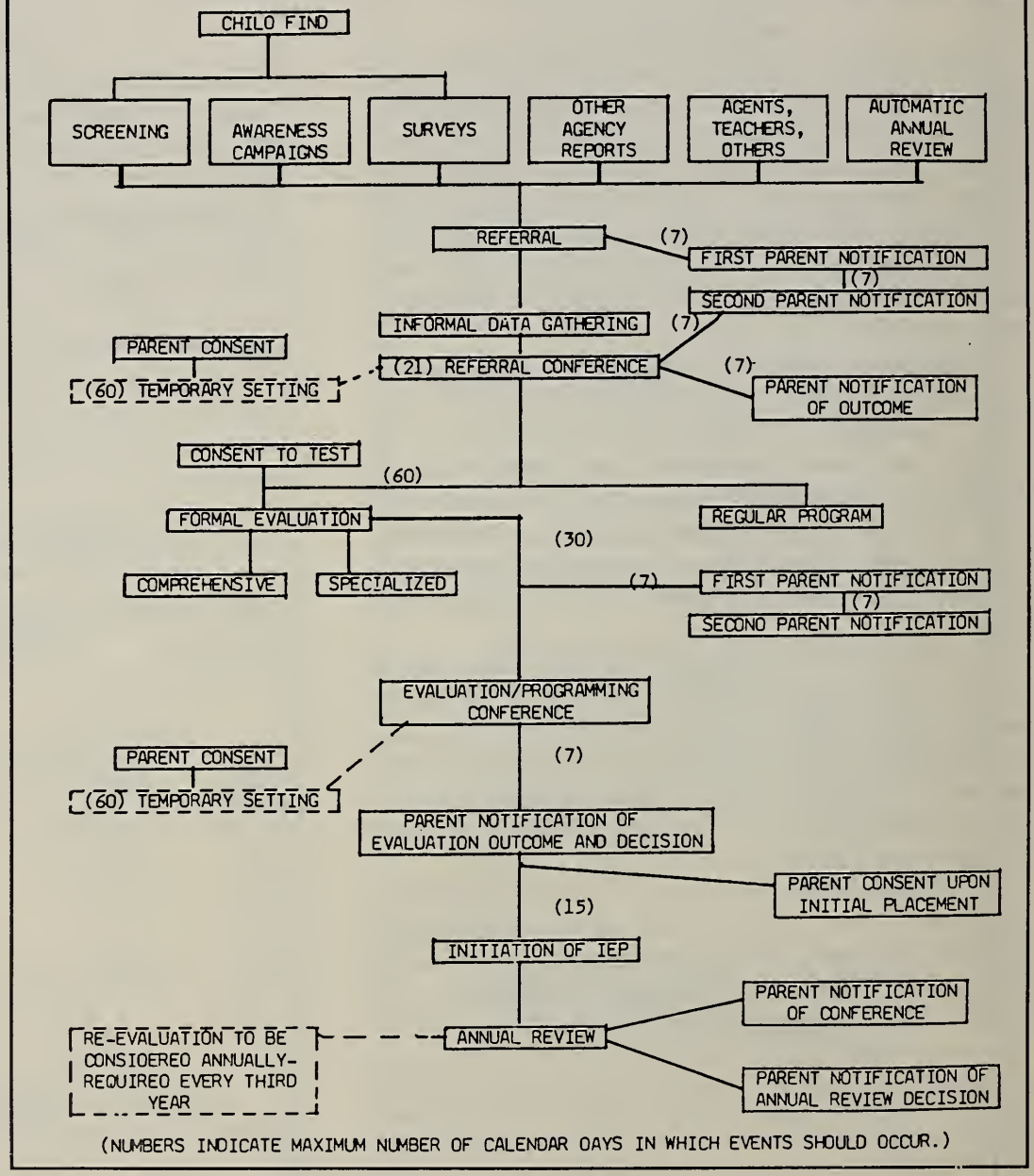
Referral

Referral is made for the purpose of compiling information about a child who is experiencing or encountering any difficulties relative to making progress in a regular education program. Referral can be made at any time, and may be made by the child's teacher, other school or district educational personnel, parents, or any individual who has relevant information about the child (to include the family physician). A written referral is made to the principal of the school in which the child is enrolled or to his/her designee. When the referral request comes from parents, other agency personnel, or other non-school individuals, a teacher or other educational personnel must complete the referral form based upon the information provided by the referring person. Any information that would assist in determining the nature of the child's learning problems must be included on the referral form as a method of informal data gathering. This information may include screening inventories, home and classroom behavioral checklists, existing medical/social/educational data, and/or samples of the child's work.

Within seven calendar working days of the receipt of the referral, the principal and his/her designee must set a date for a referral conference and send the parents notification in the form of a registered, certified, or first-class letter. Second notification is required within seven calendar days if the parents do not respond. The referral conference must be held within a maximum of 21 calendar days of the receipt of the referral.

The purpose of the referral conference is to review all existing information relative to the student and to establish what specific steps must be taken. Guidelines for the referral conference include: 1) a minimum of three people must attend (two must be the principal or his/her designee and one of the child's teachers, 2) any individual with any relevant information about the child must attend, 3) parents are informed about procedural safeguard rights, 4) all decisions are recorded, and 5) one professional assumes responsibility to assure implementation of the referral conference decision. Options for the referral conference are: 1) evaluation (specialized vs. comprehensive) or 2) no evaluation. If it is decided that further evaluation is warranted, a temporary setting for the student may be agreed upon by the parent or the guardian and the school district. This temporary placement is limited to 60 calendar days in which the evaluation must be completed; an interim individual education plan is developed for the child which sets the specific conditions and guidelines for the temporary setting.

Table II. Flow Chart for Placement Procedures



Evaluation

An informed consent statement must be obtained from the parents or the guardian of the child prior to any comprehensive or specialized evaluation. Parents must be fully informed about the kinds of tests that will be utilized in this evaluation. The purpose of the evaluation is to determine the presence of a handicapping condition which results in an educational deficit as well as a corresponding need for a specially designed instructional program. The evaluation for procedures must be completed within 60 calendar days of the referral conference decision notification of the parents.

In order to achieve as thorough an understanding of the needs of the child as possible, the assessment must include information from the school, the home, and all related community services. Measurements of the child's behavior and/or performance from a variety of settings and individuals is encouraged as a part of this evaluation process. As dictated by Public Law 94-142, the following conditions must be met in regard to the evaluation of the student prior to placement in a special education program:

1. The test and other materials are:
   a. Provided and administered in the child's native language,
   b. Have been validated for the specific purpose for which they are used,
   c. Are administered by trained personnel in conformance with the instructions provided by the producer.
2. Tests and other evaluation materials include those tailored to assist specific areas of educational need and not to provide a single general intelligence quotient.
3. The tests are selected and administered so as to best insure that the tests are administered to the child in such a way to accurately reflect the child's aptitude, achievement level, and what factors that the test purports to measure rather than reflecting the child's impairment sensory/manual, or speaking skills.
4. No single procedure is used as a sole criteria for determining an appropriate educational program.
5. Evaluation is made by a multi-disciplinary team.
6. The child is assessed in all areas related to the suspected disability.
7. All testing and evaluation material/procedures are not racially or culturally discriminatory.
8. An evaluation of the child is conducted every three years or more frequently (if conditions warrant) or on an as-needed basis if the child's parent or teacher requests the evaluation.

The components of the comprehensive evaluation includes all measures necessary to determine as precisely as possible all barriers to learning that are presented by the handicapping condition. Minimal components of the comprehensive evaluation includes: 1) academic performance, 2) intellectual skills, 3) adaptive behavior and social functioning, 4) communication abilities assessment or language abilities, 5) social history, 6) additional components (to include current health status, ophthalmological, audiological, neurological, or psychiatric evaluation), 7) specialized evaluation, and 8) evaluation procedures for suspected learning disabilities.

Within 30 calendar days following the completion of all formal evaluation activity, the evaluation/programming conference must be held. Parents must be notified of this conference within a minimum of 14 calendar days; if the parents do not respond to the first notice within seven days, a second notice must be sent.

The evaluation/programming conference is called and chaired by the professional who is designated at the referral conference to assume responsibility for having the decisions carried out. A minimum of three members must be present, one of whom must be a professional, competent to review and interpret all evaluation results. Additional members who may be included in this conference include the student's parents or guardian, student's teacher, and other professionals or special education personnel who may be involved with the provision of services.

After reviewing all the data, the persons attending the evaluation/programming conference will determine whether the child has a handicapping condition, specify the primary handicapping condition, design an individual educational plan, and determine appropriate placement for implementation of the individual education plan.

All decisions made at the evaluation/programming conference are recorded for special services within that school district. At least one professional is designated to be responsible for insuring that the decisions that are reached at this conference are carried out. Parents or guardians must be provided a written statement as to the decision within seven calendar days of the evaluation/programming conference.

Program Planning/Placement/Review

Parental consent must be obtained before the initial placement of a handicapped student in a program. Consent may not be required as a condition of any benefit to the child or the parent except in the evaluation and initial placement procedure. Continuation of placement in the same setting does not require an annual consent form; parental agreement to an annual review and acceptance of the individual education plan implies consent. However, should there be a change in the placement or the delivery of special services, an updated placement consent must be obtained.

A written individual education plan (IEP) must be established for each child which contains the annual and short-term instructional objectives for the child's progress in the school with a time table for reaching each objective, must be based upon the needs of the child as determined by a formal reassessment conducted at least every three years, and must be developed by a team representing the various viewpoints in areas of expertise relative to the child's needs.

The individual education program defines the following: 1) what should be taught, 2) who will teach it, 3) where it will be taught, 4) when the program will begin and how long the services will be provided and reviewed, 5) how much time the chid will spend with non-handicapped children, and 6) why the plan is needed based upon the assessment of the needs.

The program includes a justification for the proposed plan in accordance with the "least restrictive environment" principle as outlined by Public Law 94-142. The program must be reviewed at least once per year. Also, the physical education, vocational, and the extended or related services needed for the child are included in the IEP to include 1) counselling and therapy, 2) diagnostic medical services, 3) occupational therapy, 4) physical therapy, 5) specialized equipment, 6) specialized transportation, 7) educational aids, 10) in-service, 11) curriculum development, 12) orientation/mobility, and 13) interpreter services.

The school is required to implement the individual education plan within 15 days of the writing unless the parents disapprove. If an objection is made, the student will remain in the current educational placement pending the outcome of an appropriate review procedure.

It is the policy of the Arkansas Department of Education that the handicapped children have the right to be educated with their non-handicapped peers unless clear evidence is available that partial or full removal is desired for the welfare of the child and other children. When the child is assigned to a special program educational goals are specified; when these goals are met the child is returned to the most normal setting possible which must be consistent with the child's capabilities and educational needs.

The local school district must inform the parents at the evaluation/programming conference that they have the right to obtain an independent evaluation (at public expense) if they disagree with the evaluation provided by the local school district. However, the local school district may initiate a hearing to show that its evaluation is appropriate; if appropriate, the parents still have the right to an independent evaluation, but not at public expense. The results of the independent evaluation obtained by the parents must be considered by the state and local educational agency in any decision made with respect to the provision of a free and appropriate public education to the child, and it may be presented by either party as evidence at a hearing regarding that child. If a hearing officer requests an independent evaluation as a part of the hearing, the cost of that evaluation must be a public expense. Any and all evaluations conducted at public expense must be conducted by personnel licensed and/or certified by the appropriate regulatory agencies and/or board according to Arkansas law.

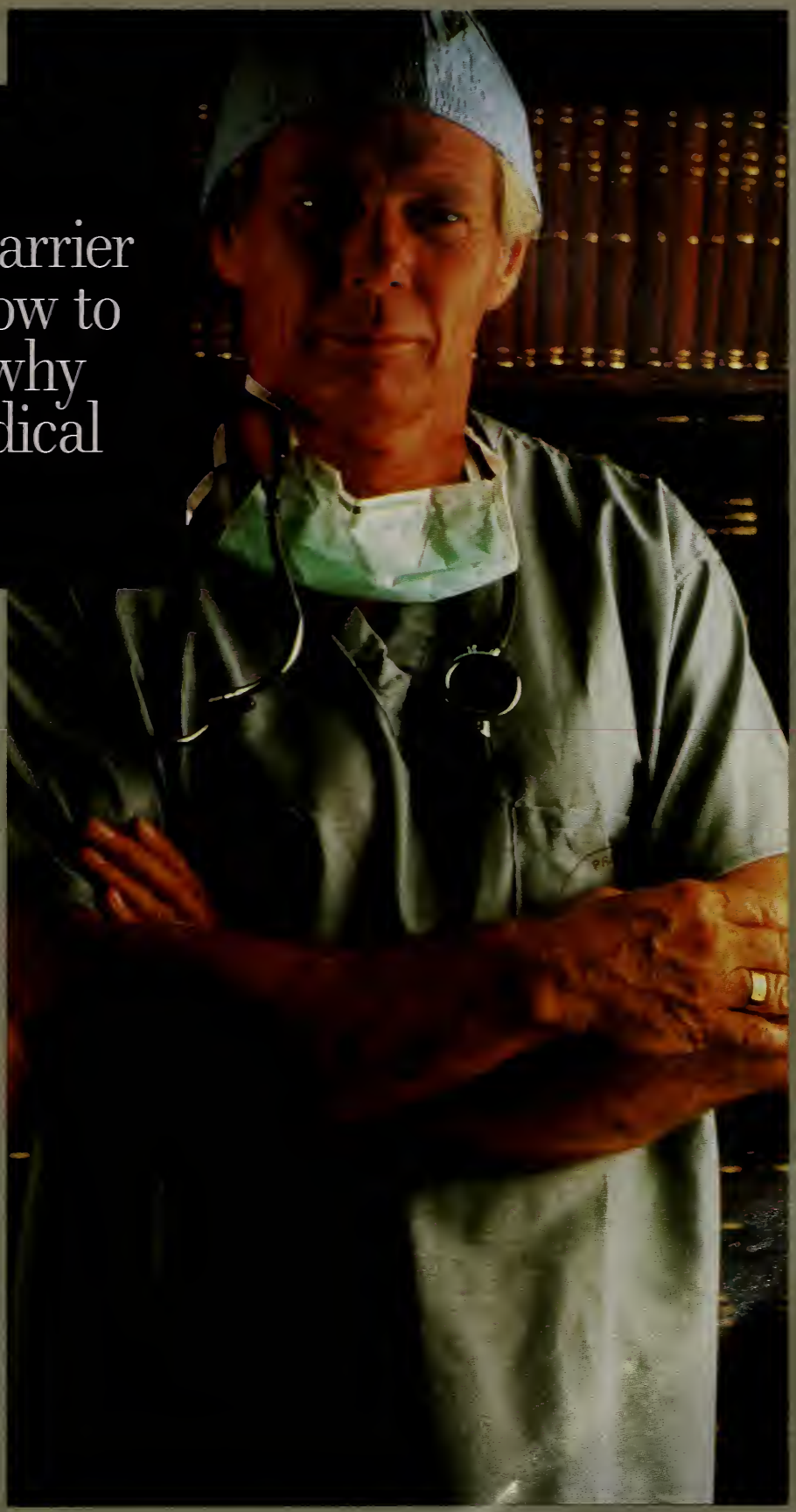
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*L. Scott Cook, M.D., Ph.D.**

Introduction

Cardiac transplantation has emerged from the research lab to become an established clinical therapy for selected patients with end stage heart disease.[1] It is estimated that 1,200 heart transplants were performed in 1987.[2] However, an estimated 15,000 more patients could have benefited from cardiac transplantation. These could not be done because of the limited number of donors. Thus, it is desirable to identify any suitable donors. It is equally important to exclude potential donors with dysfunctional hearts that could be expected to fail following transplantation. According to Saraf[3], close to 20,000 potential organ donors exist each year in the U.S., but viable organs are obtained from only 2,500.

Discussion

Donors with the possibility of cardiac dysfunction have been excluded. Thus, it has been current practice to exclude potential cardiac donors with severe chest trauma, prolonged hypotension, age greater than 40 years or donors receiving high dose catecholamines (dopamine > 10 mcg/kg/min).[4] Direct inspection during organ harvesting has been the definitive method of identifying cardiac dysfunction. Echocardiographic evaluation of potential cardiac transplant donors is helpful in evaluating cardiac dysfunction. Of the potential cardiac donors available, only 27-40% are utilized as organ donors.[4] In many instances, these organs were not utilized because of cardiovascular instability of the donor.[4] Cellular myocardial damage and cardiovascular instability have been reported during experimental brain death in animals and clinical brain death in humans.[5] The care of the donor and the timing of organ retrieval are very important in successful cardiac transplantation.

Criteria for Cardiac Donation

The general criteria for cardiac donation are as follows: documented or clinical neurological death, age of donor - 40 years or less for male donors and 45 years or less for female donors; no history of cardiac disease; no Q waves on the electrocardiogram; no period of prolonged hypotension;

Table I. UNOS Minimum Data Requirements for Heart Offer

Essential Information

Mechanism of brain death;
Any documented cardiac arrest or hypotension;
Vital signs to include the blood pressure, heart rate and temperature;
Cardiac, social, drug, and activity history;
Serologies for HIV and hepatitis;
Accurate height, weight, age and sex;
ABO type confirmed;
Interpreted electrocardiogram and chest radiograph;
Donor course in hospital to include pressor requirement and fluid status;
CMV serology;
Accurate chest size measurements (for heart/lung);
Arterial blood gas results and ventilator settings.

Desirable Information

Echocardiogram desirable for all donors, especially those who are marginal by any criteria;
Coronary angiography for male donors over the age of 40 and female donors over the age of 45;
CVP or Swan Ganz instrumentation if possible;
Cardiology consult;
Cardiac enzymes including CPK isoenzymes;
ABO type confirmed on two separate determinations

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minimal inotropic support, and recipient to donor weight difference not greater than 20kg. Consent must be obtained from the legal next of kin.

ARORA/UNOS

Arkansas Regional Organ Recovery Agency (ARORA), phone number (501) 224-2623, is the local agency for organ procurement in Arkansas. ARORA is a member of United Network for Organ Sharing (UNOS) which is the National Organ Procurement and Transplantation Network. In order to obtain donor organs for transplantation the participating hospital must be approved by UNOS. The University of Arkansas Hospital in Little Rock has been UNOS-approved for renal transplantation since 1965. In December 1988, the Heart Transplant Program at the University Hospital received approval to begin cardiac transplantation.

UNOS has determined minimum data requirements for a heart offer. This information is detailed in Table I. Furthermore, the heart procurements team must have the opportunity when necessary to speak directly with responsible ICU personnel or the onsite donor coordinator.

UNOS has developed new criteria for allocation of hearts. Hearts will be allocated to locally waiting recipient candidates on the basis of identical blood groups unless medical urgency dictates otherwise. The two urgency categories of waiting heart recipients are defined in Table II.

The "time of waiting" begins with the date and time the patient was activated on the UNOS computer. The distance of the recipient hospital from the donor hospital will also be used to prioritize the recipient list for hearts not used by the local organ procurement agency. Three zones will be defined by concentric circles of 500 and 1,000 mile radii with the donor hospital as the center.

Donor Care

The brain dead donor is continuously monitored by arterial line, a central venous pressure line, and a Foley catheter. Other supportive care includes mechanical ventilation to maintain normal acid-base and arterial blood gas values. The serum electrolytes must be maintained within normal limits. Hypothermia and hyperthermia are controlled with the use of external temperature-control blankets.

Cardiovascular instability is often related to hypovolemia, the donor must be fully volume loaded to prevent hypotension. Most episodes of hypotension occur with arteriolar and venous dilatation due to peripheral sympathetic withdrawal. The rapid infusion of large volumes of fluid becomes necessary to maintain extracerebral perfusion.

The development of diabetes insipidus in the donor is cause for concern. The donor may develop cardiovascular instability due to the large intravascular volume shifts causes by urine outputs greater than 1 liter per hour. It should be treated with intravenous vasopressin or intranasal desmopressin and the volume lost in urine must be replaced with appropriate electrolyte solution.

Table II. UNOS Urgency Categories for Recipients

Status I - Patients requiring cardiac and/or pulmonary assistance with one or more of the following devices in place:

(i) Total Artificial heat (TAH)
(ii) Left and/or Right Ventricular Assist System (LVAS);
(iii) Intra-aortic balloon pump;
(iv) Ventilator

or patients meeting *both* of the following criteria;

(i) The patient is in an Intensive Care Unit; and
(ii) The patient *requires* inotropic agents to maintain adequate cardiac output.

Status II - All other waiting patients who do not meet the Status I criteria.

Another potential problem in the donor patient is hypertension. Investigators[6] have shown that an increase in the intracerebral pressure results in massive sympathetic discharge, causing elevated systemic vascular resistance, marked hypertension, and cardiac failure. Severe sustained hypertension, due to increased intracranial pressure causes irreversible myocardial damage.[7] Vasodilators such as sodium nitroprusside can be used for afterload reduction in this circumstance. The systolic blood pressure should be maintained in the range of 100 to 120 mm Hg systolic. Preparation of a brain-dead patient for organ donation requires a combination of continuous cardiovascular monitoring, critical care medicine and timely communication with the transplanting center to assure the best function of the posttransplant organ.

We have an ongoing research project in both brain dead animals and humans designed to evaluate the effects of both catecholamines[8] and thyroid hormones upon cardiovascular function. This may lead to the use of both alpha and beta receptor blocking agents in the brain dead donor in the hopes of improving cardiovascular stability.

Selection of Recipients

The selection of recipients for cardiac transplantation remains difficult and potentially controversial even though the technology of transplantation is 20-years-old. Considerable clinical judgement must be utilized.

End-stage heart disease can result from a diverse group of pathophysiologic processes, including congenital heart disease, acquired valvular disease, myocarditis, coronary artery disease and cardiomyopathy. Prognostic factors that indicate a poor survival in cardiomyopathy include: 1) age > 50 years, 2) congestive heart failure, 3) cardiomegaly, 4) cardiac index < 2.5 1/min/m^2, 5) LVEDP > 20 mm Hg, 6) ejection fraction < 0.20%, and 7) arrhythmias, atrial and/or ventricular.[9] In prospective studies the left ventricular ejection fraction has been the best indicator of survival. Left

Table III. Contraindictions to Cardiac Transplantations

Absolute and relative contraindications to cardiac transplantation include:

(1) Cardiac patients with a fixed pulmonary vascular resistance exceeding 6-8 Wood units should not be transplanted because the normal right ventricle of a transplanted heart cannot acutely adapt to such afterload and would develop acute right heart failure;
(2) Potential recipients with active infection must be excluded because it would be exacerbated by immunosuppressive therapy;
(3) Patients with a recent pulmonary infarction must be excluded because this predisposes them to lung cavitation and secondary infection;
(4) Patients in whom cytotoxic antibodies have been detected through a positive cross match between their serum and donor lymphocytes should not be transplanted because of the risk of rejection;
(5) Active peptic ulcer disease patients should be excluded until their GI status improves. Their condition might be exacerbated by doses of cortocosteroids;
(6) Significant peripheral vascular or cerebrovascular disease is a relative contraindiction;
(7) Patients with recent malignancies should be excluded;
(8) Patients with chronic bronchitis and emphysema should not be transplanted because of their predisposition to infection;
(9) Those patients who are psychosocially unstable are not suitable candidates.

ventricular ejection fraction < 0.10 predicts an extremely poor prognosis (6-month survival was 17%). No patient with LVEF ≥ 0.20 died within 6 months of assessment. For those patients with LVEF between 0.11 and 0.19, survival after cardiac transplantation exceeded that of the natural history of their disease; suggesting that transplantation should be undertaken within 6 to 12 months of assessment.[10]

Those candidates who are most likely to benefit from cardiac transplantation undergo systematic and extensive medical screening. A complete physical examination, ECG, chest x-ray, pulmonary function evaluation and routine laboratory tests are performed. Patients are screened for exposure to Epstein-Barr virus, cytomegalovirus, tuberculosis, fungal diseases and toxoplasmosis because the results of such screening are helpful in diagnosing postoperative reactivation of a latent bacterial or viral infection, or the transmission of one of these from the donor to the recipient.

The pretransplantation evaluation should identify any systemic illness that could hinder postoperative recuperation and limit rehabilitation following a successful heart transplantation. It will also detect irreversible damage to the central nervous system, liver or kidneys which would cancel the planned procedure. A list of contraindictions to transplantation is shown in Table III.

Conclusion

In summary, potential candidates for heart transplantation should have (1) terminal cardiac disease and an estimated life expectancy of less than 12 months; (2) be less than 60-65 years of age; (3) have normal or reversible renal and hepatic function and (4) be free of infection.

The present one-year survival rate following heart transplantation is greater than 80% and provides this patient population with renewed hope. The heart transplant program at the University of Arkansas Hospital is interested in the recruitment of both cardiac transplant recipients and donors.

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ELECTROCARDIOGRAM of the MONTH

William Roberts, M.D.
John W. Watson, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

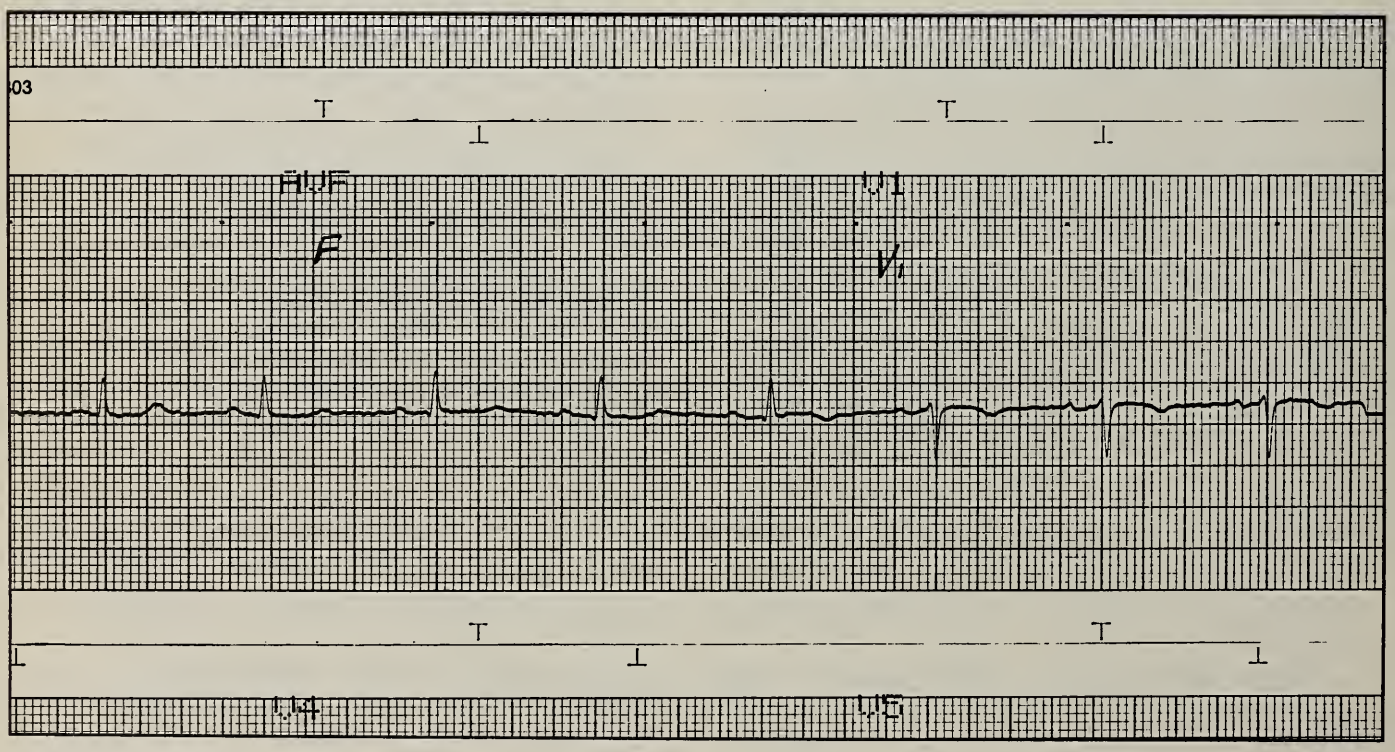
CLINICAL HISTORY:

M.P. is a 90-year-old lady with congestive heart failure of a chronic nature thought to be secondary to cardiomyopathy. She takes Lanoxin 0.125 mg. daily to help with her compensatory status. Chronic renal failure has also been diagnosed in the past and has slowly progressed. Recently, she was seen for visual changes, nausea, and vomiting. What do you think about her electrocardiogram?

DISCUSSION:

Except possibly for the cardiac mechanism, the electrocardiogram is normal. There are no ST-T changes of digoxin effect. Lead V_2 suggests the presence of atrial tachycardia with atrial rate 250/minute and ventricular rate approximately 80/minute. The differential possibilities, with respect to the cardiac mechanism, would include atrial tachycardia with variable block. One would wish to be assured that the P-waves seen best in Lead V_2 are not actually "pseudo-P-waves" actually representing artifact of some type. On the basis of the history, digoxin intoxication is a strong possibility in this patient. Atrial tachycardia of paroxysmal type with block is often a manifestation of digoxin intoxication.

The editor wishes to thank Dr. Roberts of Conway for his help with this month's ECG.



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Adenocarcinoma of the Small Intestine

Jacob Amir, M.D., William E. Atkinson, M.D., W. Ducote Haynes, M.D., and Jerry L. Prather, M.D.

Problem

The case of a 63-year-old woman with a previous diagnosis of adenocarcinoma of the small intestine[1-3] with metastases to the omentum was presented to the Second Opinion Panel for a discussion of the patient's treatment options.[4,5]

In March 1986, the patient was found to have iron deficiency anemia. Upper G.I., small bowel follow-through, air contrast barium enema and evaluation of her stools for occult blood did not reveal the cause of her anemia. After showing some improvement with iron therapy, she began to have pain and slight anemia again in July 1986. A colonoscopy and EGD were done and revealed mild gastritis. Abdominal pain persisted, and in September 1986, a repeat EGD with endoscope advanced past the duodenum and into the jejunum revealed a tumor. An exploratory laparotomy revealed adenocarcinoma of the jejunum, and a small bowel resection was performed. The patient received adjunctive chemotherapy consisting of 5-FU monthly for four months.

Approximately four weeks postchemotherapy, the patient reported to her physician with signs of possible obstruction. A chest x-ray and acute abdominal series were made and were nondiagnostic for mechanical bowel obstruction. During the next two months, the patient continued to have intermittent abdominal symptoms and showed response to IV fluids and NG suction.

In April 1987, upper G.I. series revealed an obstruction at the distal small bowel. The patient underwent a second exploratory laparotomy, which revealed carcinomatosis with fairly extensive disease of the pelvis. A small bowel resection, palliative enteroenterostomy and left oophorectomy were performed. The patient received chemotherapy consisting of 5-FU and mitomycin from May through September 1987. In October 1987, a mass was felt upon rectal examination. A CT was done and was normal. No malignancy was found on a transrectal biopsy. An ultrasound was done in December and was reported to show a cyst/solid complex along the cul de sac and left adnexa. The mass continued to be felt upon rectovaginal exam, and a biopsy of the umbilicus in January 1988 confirmed metastatic disease. Planned treatment included a change in chemotherapeutic agents since the tumor apparently recurred while chemotherapy was being given.

The patient was hospitalized for intestinal obstruction at which time several members of her family met with the panel for a discussion of her case.

St. Vincent Infirmary Cancer Center, Two St. Vincent Circle, Little Rock, Arkansas 72205-5499

Pathology Review
Dr. Atkinson

The histopathologic material was examined, and we agreed with the diagnosis of poorly differentiated mucinous adenocarcinoma of midjejunum metastic to mesentery and pelvis.

Diagnostic X-ray Evaluation
Dr. Prather

X-rays taken one day prior to discussion were reviewed and showed a small bowel obstruction. A CT scan of the abdomen and pelvis taken in October 1987 showed that the lesion (referred to as a cyst on the radiology report) had not changed from a previous CT scan. However, an unclear area in the pelvis, which could be the uterus or a mass, needs to be further identified. The patient should have another pelvic CT done to delineate this area.

A CT scan done in March 1987 was also reviewed and showed huge obstructive loops. The ultrasound done in December 1987 was not available for review.

Radiation Therapy Option
Dr. Haynes

This patient has shown progressive disease while on mitomycin-C and 5-FU. Her physician's recommendation to try a second-line regimen is appropriate since she did not

respond to first-line chemotherapy. However, second-line drugs are generally less effective, and curative treatment is unlikely for this patient. If local symptomatic problems occur, palliative radiation therapy could be used.

Medical Oncology Opinion
Dr. Amir

This patient was treated with adjunctive chemotherapy when adenocarcinoma of the small bowel was first diagnosed in September 1986 and again when metastatic disease was diagnosed in April 1987. However, chemotherapy was discontinued when a mass was felt on rectal vaginal exam in October 1987. A navel biopsy taken three weeks prior to the panel discussion showed the same tumor originally diagnosed in 1986.

Since the patient is presently hospitalized for an apparent intestinal obstruction, the obstruction will have to be relieved before any further treatment for cancer can be undertaken. If a trial of tube suction decompression offers no relief, the mass should be removed surgically.

After relief of the obstruction either by conservative or surgical means, it would be appropriate for this patient's chemotherapy regimen to be changed to second-line drugs since there was no response to first-line drugs. The panel felt that a change in chemotherapy was the only viable option available to this patient for slowing the progress of her disease. We did not feel that chemotherapy offers treatment for cure at this point.

Consensus

The panel agreed with the diagnosis of primary adenocarcinoma of the midjejunum with metastases to the mesentery and pelvis. It was concluded from reviewing the radiographic studies that there was residual tumor in the pelvis. It was the opinion of the panel that the treatment thus far had been timely and appropriate. The panel emphasized the importance of relieving that obstruction before any treatment for the cancer be undertaken.

Since the tumor had apparently recurred during the administration of chemotherapy, it was appropriate for the patient's physician to use alternative chemotherapeutic agents. However, second-line chemotherapy drugs would be used to control the growth of the tumor for a period of time rather than to cure the disease. At some time in the future, the patient might decide to discontinue her chemotherapy. This would be a decision that should be made after the patient and her family discuss the advantages and disadvantages with the patient's oncologist. Radiotherapy was not recommended as a treatment option.

Acknowledgement

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Hypohidrotic Ectodermal Dysplasia: A Review

*Terrence L. Champlin, B.S., and Susan B. Mallory, M.D.**

Introduction

Hypohidrotic ectodermal dysplasia (HED), also known as anhidrotic ectodermal dysplasia or Christ-Siemens-Touraine syndrome, is an uncommon X-linked recessive disorder, occurring in 1 per 100,000 births. It is found in all racial groups and in all areas of the world.[1] HED was first described in 1848 by Thurman, and later in the 19th century by Darwin.

The ectodermal dysplasias form a large group of disease, with much confusion regarding classification. The classification by Freire-Maia categorizes the ectodermal dysplasias into over 100 separate disorders according to subgroups 1-2-3-4 for the features of the disease: trichodyplasia (1), dental defects (2), onychodysplasia (3), and dyshidrosis (4).[2] Common features of ectodermal dysplasias are abnormalities of tissues of ectodermal origin due to developmental disturbances in the embryonal state.[3] Table I shows the tissues and structures of ectodermal origin. Solomon et al[4] proposed that to be considered an ectodermal dysplasia, a disorder should meet several criteria: 1) the disease must be congenital (present at birth), 2) the disease must be diffuse and involve the epidermis as well as one of its appendages such as hair, sebaceous glands, nails, mucosa, mucosal glands, or teeth, and 3) the disease is not progressive. In fact, the patients often improve over a period of years.[5]

Genetics

HED is an X-linked recessive disease, with roughly 70% of the heterozygous females exhibiting partial or minor forms of the syndrome such as hypotrichosis, hypodontia, microdontia, hypohidrosis, patchy mosaic distribution of body hair and sweat pores.[2] The varying degrees to which the females are affected can be explained in terms of Lyonization, the random inactivation of one X chromosome and the expression of the other X chromosome. Clinical features of affected males will be discussed in more detail later. The gene locus has been mapped to the proximal part of the X-chromosome long arm, Xq, near the centromere.[1]

Clinical Features

HED is clinically characterized by hypodontia or anodontia, hypohidrosis or anhidrosis, alopecia in a setting of generalized hypotrichosis, and occasionally onychodysplasia.[5] The skin is soft, thin, and dry[6] and patients often have atopic dermatitis.[1] Typical facial features are saddle-shaped or depressed nasal bridge, protruding and everted lips, hypotrichosis, and sparse or absent eyebrows and eyelashes. Figure 1 shows that a variable number of missing and malformed teeth can further change the facial appearance because of the lack of lip support and a decreased lower

Table I. Tissues of Structures Derived from Ectoderm[4]

- Ectodermal Structures
  - Keratinocytes
  - Melanocytes
  - Sebaceous glands
  - Eccrine glands
  - Apocrine glands
  - Nails
- Teeth
- Eye
  - Lens
  - Conjunctiva
- Anterior pituitary gland
- Nipples
- Ears
- Mucosal surfaces
  - Mouth
  - Nose
  - Rectum
- Central nervous system
- Medulla of adrenal glands

Arkansas Children's Hospital, 800 Marshall Street, Little Rock, Arkansas 72202.



Figure 1. Abnormally shaped teeth in patient with ectodermal dysplasia. Note there is mild dystrophy of the nails as well.

facial height (distance from chin to nose). Patients may also have periorbital hyperpigmentation,[7] fine wrinkling around the eyes, and milia-like papules secondary to a few hyperplastic sebaceous glands. Patients with HED are usually of normal intelligence, especially when protected from febrile convulsions.[6]

Otolaryngologic manifestations caused by the maldevelopment of the exocrine glands result in a decrease of secretions, which are quite tenacious and can cause nasal obstruction and crusting with secondary infection of the nose and paranasal sinuses. The saddle-nose deformity creates an anatomic nasal obstruction, and may require surgery to correct. Difficulty with chewing and swallowing results from the altered salivary production. Dysfunction of minor salivary glands leads to hoarseness from inadequate lubrication of the vocal cords. Chronic laryngitis results from thick nasal discharge. Decreased tracheobronchial secretions predisposes to recurrent pulmonary infections. Disruption of the orderly migration of squamous epithelium in the external auditory canal causes frequent cerumen impaction.[8]

Other features are atrophic rhinitis, amastia, and primary hypogonadism.[5] Abnormalities of the ears, such as satyr ears, bat ears, or absence of some folds, are reported in about 30% of the cases.[9] Eye problems, such as photophobia, result from decreased lacrimal activity and dryness, and abnormal eyelashes may produce chronic irritation.[7] Table II shows the characteristics of Hypohidrotic Ectodermal Dysplasia.

Diagnosis

X-linked recessive HED often goes undiagnosed at birth because of the difficulty in recognizing the subtle craniofacial manifestations that may be present. Frequently, the diagnosis will be made several months later when the child presents with recurrent high fevers. These boys have heat intolerance as a result of hypoplasia of the sweat glands, which compromises the ability to regulate body temperature. They are prone to rapid onset of high fevers with no infectious etiology, but in the presence of an infection may have very high, life-threatening fevers.[7] Early diagnosis is important to avoid brain damage or death secondary to hyperpyrexia. Therefore, the earliest clues of HED might be fever of unknown etiology in a male infant who has scant blond hair and missing eyebrows or lashes.

If HED is suspected, mandibular radiographs may reveal anodontia or hypodontia. Examination of family members may reveal affected siblings, and heterozygote mothers may show missing or conical teeth. The diagnosis can be established through sweat pore counts and/or palmar skin biopsy.[10]

Several methods of counting sweat pores have been proposed, including direct counts under a stereo microscope, plastic imprinting, wax casts, cellulose acetate, O-ophthaldehyde in xylene, and starch iodine. O'Leary et al have devised a simple method in which the areas to be printed are rubbed with alcohol followed by pencil carbon.[11] Cellulose tape is applied, lifted off and transferred to a glossy white paper, resulting in a permanent record. The sweat pores are then counted under a microscope at 12X magnification. Affected patients show no sweat pores; controls have approximately 21 sweat pores per centimeter of dermal ridge, and the obligate heterozygote carriers have about 10 pores per centimeter.

Lambert and Bilinski advocate the use of palmar skin biopsy for the diagnosis of HED, citing a number of flaws in the use of noninvasive techniques of pore counting.[12] Differentiation of the intraepidermal portion of the eccrine sweat gland duct proceeds by a markedly different pathway than that of the dermal portion of the duct. This can allow partial differentiation of the intraepidermal portion of the

Table II. Characteristics of Hypohidrotic Ectodermal Dysplasia

- Hypondontia, anodontia
- Anhidrosis
- Hypohidrosis
- Onychodysplasia
- Facial features
  - Frontal bossing
  - Sunken cheeks
  - Saddle-shaped nasal bridge
  - Recessed columella
  - Decreased lower facial height
  - Periorbital pigmentation/wrinkling
- Abnormalities of the breast
- Abnormalities of the ears
- Nasal obstruction/crusting
- Difficulty with chewing and swallowing
- Hoarseness/chronic laryngitis
- Recurrent pulmonary infections/asthma
- Cerumen impaction
- Photophobia/conjunctivitis

eccrine duct without evidence of formation of a dermal eccrine duct or gland. This casts doubt on the validity of pore counting by noninvasive methods for diagnosis of HED. The palmar biopsy, showing absent or reduced sweat glands and ducts, produces negligible morbidity, carries little risk, and almost always gives unequivocal results.

Management

An Ectodermal Dysplasia Clinic at Arkansas Children's Hospital with a multidisciplined approach has been established. Persons involved in the clinic are Laura Keppen, M.D. (geneticist), Peter Hayes, D.D.S (dentistry), and Susan B. Mallory, M.D., (dermatology).

The most important aspect of management is the prevention of hyperthermia, particularly in the infant who cannot control his external environment. This necessitates the avoidance of high ambient temperatures, warm clothing, and physical overexertion.[10] Temperature control in older children can be helped by cool surroundings, drinking cool fluids, taking cool showers or wearing wet T-shirts.[1] Another method of thermoregulation involves the use of cooling suits which are connected to a portable pump and which circulates coolant through the suit. These suits are adequate during sedate activities but are not sufficient in strenuous exercise, and have the added disadvantage of the 20-pound reservoir and battery pack which limits the portability, especially in young patients.

Patients with HED have an increased risk of developing viral and bacterial infections in the respiratory system, probably because of a virtual absence of seromucous glands in their respiratory tracts.[13] With poor respiratory cleaning there is an increased incidence of bronchitis and pneumonia.[5] Since infections in HED patients can rapidly lead to high fever, some in fact might benefit from prophylactic antibiotics.[1] Asthma is another common feature. Therefore, the patient with HED should be advised not to smoke or work in a hot or dusty atmosphere. Some authors have reported primary immune dysfunction[13], while other do not concur.[1]

Beginning at an early age, regular dental care is necessary. Fitting of dentures as early as age 3 or 4 years can help the patient's speech, facial appearance and nutrition.[9] Bonding is an option for patients unable to accept dentures.[7]

The otolaryngologist can play a role in the management of these patients. Nasal obstruction and crusting can be treated with saline nose drops or commercial solutions, and home humidifiers. Difficulty with chewing and swallowing can be offset by consumption of large quantities of fluids during and between meals, or by the use of sialogogues or artificial saliva preparations such as Xerolube. Regular cerumen impaction may require removal by a physician or use of lubricating drops.[8]

Xerophthalmia, or decreased lacrimal gland secretion, can be treated with artificial tears to avoid conjunctivitis.[10] Dry skin and mucous membranes require daily care with emollients.

Finally, the educational, social, and emotional problems must be addressed. These patients may require special classes. Wigs, dentures, and even plastic surgery for ear and nose deformities may help improve the patient's appearance and self-esteem. Severe bouts of depression and suicide attempts are not uncommon. These problems may require psychiatric help.[6] Also, genetic counseling is indicated if more children are anticipated.[10]

Summary

HED is an X-linked recessive disease involving abnormalities of tissues of ectodermal origin due to developmental disturbances in the embryonal state. These abnormalities include 1) trichodysplasia, 2) dental defects, 3) onychodysplasia, and 4) dyshidrosis. Also common are thin, dry skin, typical facial features such as saddle-nose deformity and periorbital wrinkling/pigmentation, otolaryngologic problems, eczema, and respiratory disease. Diagnosis of HED may be suspected in a child with recurrent fever of unknown etiology, thin blond hair, and anodontia. The diagnosis can be strengthened by low or absent sweat pore counts, and confirmed by palmar skin biopsy. Management is multidisciplinary and mainly involves avoidance of hyperpyrexia in the early years. At school age and beyond, the cosmetic features become more of a concern to the patient. As adults, these patients usually lead fairly normal lives both physically and socially, and have a life expectancy similar to that of the general population.

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Nutrition and Aging V

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September 15, 12:30 p.m. Presented by Fred Hagemeier, Ed.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Hogamania Program (Upper GI Disorders)

September 16, 7:30 - 10:00 a.m. Presented by Lee Parker, M.D. Sponsored by UAMS AHEC Northwest. Washington Regional Medical Center, Baker Conference Center, 1125 N. University, Fayetteville. Two Category I credit hours. Fee: $10, includes breakfast.

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October 5, 12:00 noon. Presented by Charles Paris, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

HIV Testing and Counseling

October 12, 12:30 p.m. Presented by Jim Acklin, M.D. and Russell Williams, MSW. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Effect of Drugs on Renal Function with Emphasis on NSAI

October 18, 12:00 noon. Presented by Andrew Whelton, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

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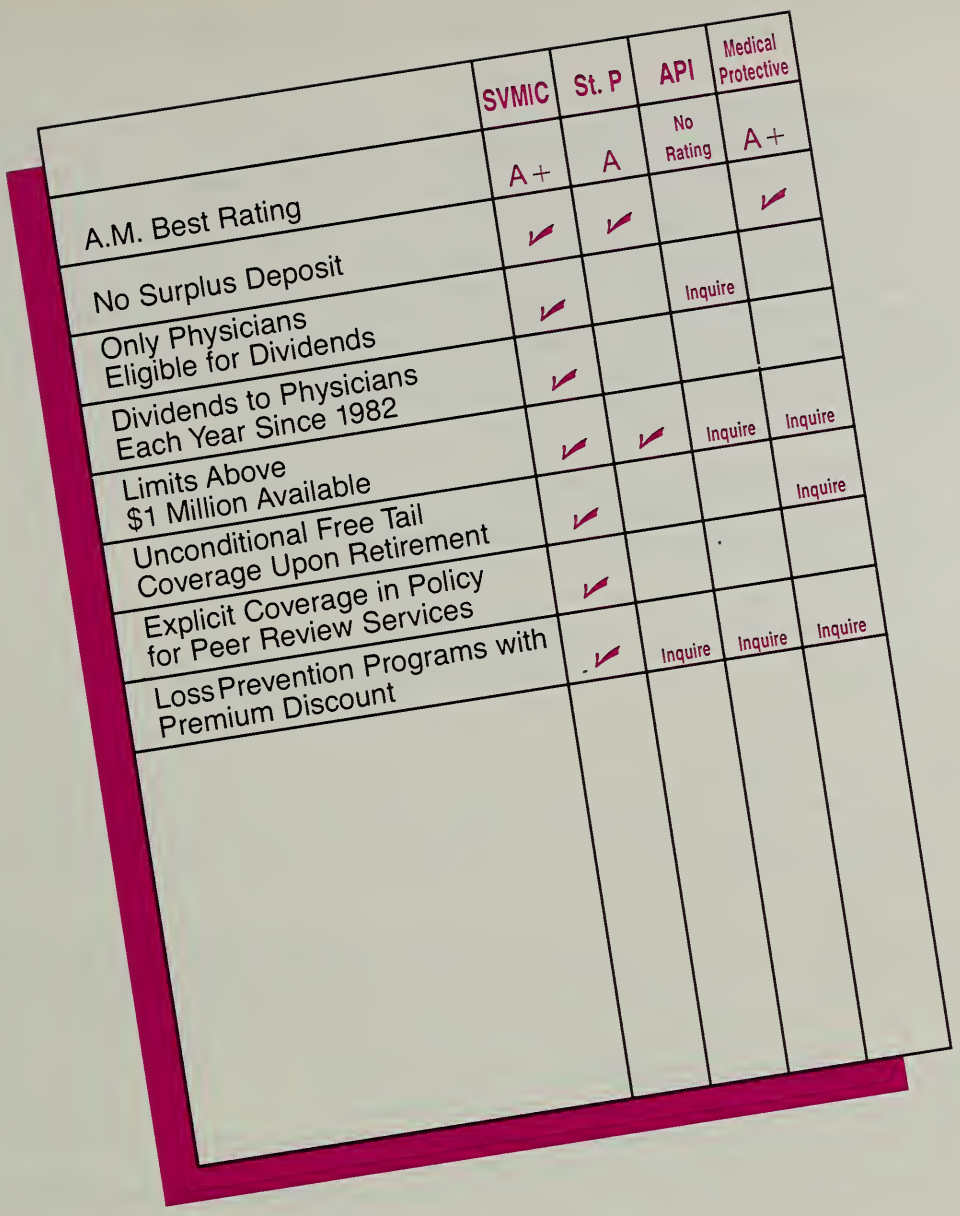
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HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, Sturgis Building, Room 121
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Second Floor Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, Sturgis Building, Rooms S120-121
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Cancer Conference, first Wednesday, 12:00 noon, CARTI Auditorium. A meal is provided.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell Room. A meal is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. A meal is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Arkla Room. Refreshments are provided.
Internal Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. A meal is provided.
Pediatric Conference, first Tuesday, 12:30 p.m., LaHarpe de Paul Room. A meal is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
GI Conference, third Thursday, 12:00 noon, Conference Room 1.
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, fourth Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS Education Building, Room G137, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B.
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH.
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33.
Ob/Gyn Grand Rounds, Wednesdays, 7:30 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Fundamental Sciences Conference, first Tuesday, 6:00 p.m., UAMS Chancellor's Area, Conference Room B-2

Surgery Grand Rounds, one Saturday per month, 8:00 a.m., UAMS Education Building, Room G/141A, 1.5 credit hours
Surgery Morbidity and Mortality Conference, Wednesdays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Resident Case Conference, Mondays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Review Conference, Mondays, 6:00 p.m., UAMS Education Building, Room G/141A
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Conference (Pediatric), once monthly, 5:00 p.m., Arkansas Children's Hospital, Sturgis Building, Clinic 2
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Tuesdays, 5:00 p.m., UAMS Education Building, Room G/131A&B

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:15 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:15 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:15 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:15 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:15 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:15 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:15 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
Family Medicine Conference, eacg Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tueaday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village.
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff.
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center

Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

MEDICINE IN THE NEWS

Empire Casualty Company Insolvent

The Arkansas Medical Society has received notice that the Empire Casualty Company is in a state of receivership. The company may have written malpractice insurance for physicians and other health care providers in Arkansas through 1984. If physicians are insured by the company, they may file claims before the deadline of September 30, 1989, and, more importantly, have the opportunity to insure themselves for possible incurred but as yet unknown claims which may surface after the claim filing deadline.

Below is the notice to policyholders, claimants and creditors of Empire Casualty Company concerning the opportunity to file claims:

> NOTICE IS HEREBY GIVEN that Empire Casualty Company, organized under the laws of the State of Colorado, with corporate offices in Ada, Oklahoma and Denver, Colorado has been placed in receivership by Order of the District Court in and for the City and County of Denver, Colorado.
>
> Pursuant to the authority vested in the Receiver, all policy-holders, claimants and creditors of Empire Casualty Company are hereby given the opportunity to file notice and proof of claim with the Receiver of Empire Casualty Company.
>
> Notice and proof of claim must be addressed and postmarked to the Receiver at his address by midnight, September 30, 1989. NO LIABILITY, INDEMNITY, OR CLAIM, KNOWN OR UNKNOWN, WILL BE CONSIDERED IN THE RECEIVERSHIP UNLESS SUCH BECOMES KNOWN AND REPORTED TO THE RECEIVER ON OR BEFORE THE CLAIM FILING DEADLINE.
>
> Claim forms are available from, and must be filed with, Robert D. Balzano, Receiver, Empire Casualty Company, 333 W. Colfax Avenue, Suite 515, Denver, Colorado, 80204.
>
> Claims allowed by the Receiver will share in the distribution of assets of this company according to section 10-3-507 (3) Colorado Revised Statutes. Claimants will receive notice of allowance or disallowance of their claim and its priority classification by the Receiver.
>
> PERSONS WITH MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE WRITTEN ON AN OCCURRENCE CONTRACT MUST OBTAIN RUN-OFF OR "TAIL" COVERAGE FROM ANOTHER INSURER OR RISK PERSONAL LIABILITY FOR INCURRED BUT UNKNOWN CLAIMS. CONSULT AN INSURANCE COMPANY OR AGENT ABOUT THIS COVERAGE.

Arkansas Caduceus Club Presents Awards at Annual "Alumni Weekend"

A faculty member at Washington University School of Medicine and two members of the College of Medicine faculty at the University of Arkansas for Medical Sciences were honored at a dinner recently in conjunction with the Arkansas Caduceus Club Alumni Weekend Activities. The dinner was held at the Country Club of Little Rock with more than 200 graduates of the UAMS College of Medicine, guests and faculty members attending. The Arkansas Caduceus Club is the alumni organization for the UAMS College of Medicine.

John A. Pierce, M.D., (Class of '48), a native of Little Rock and professor of Medicine at Washington University School of Medicine in St. Louis, was presented the "Distinguished Alumnus Award," given annually to a former graduate of the UAMS College of Medicine who has made notable contributions to the field of medicine. Roscoe A. Dykman, M.D., a member of the UAMS

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In a Convenience Pak survey (N = 100)[1]

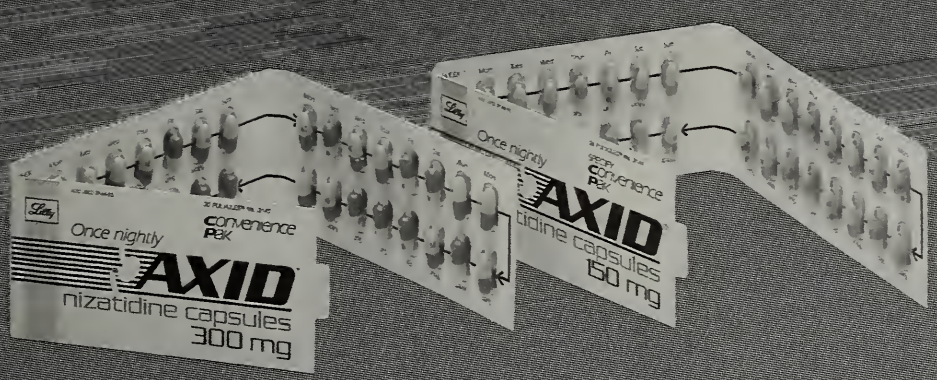
- *100% said the directions on the Convenience Pak were clear and easy to understand*
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Pharmacists save time – at no extra cost

- *The Convenience Pak saves dispensing time and minimizes handling*

The Convenience Pak promotes patient counseling

- *Pharmacists dispensing the Axid Convenience Pak can encourage compliance and continued customer satisfaction*



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Eli Lilly and Company
Indianapolis, Indiana
46285

1. Data on file, Lilly Research Laboratories.

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Additional information available to the profession on request.

AXID®

nizatidine capsules

Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

College of Medicine's Department of Psychiatry and Behavioral Sciences for 33 years, and Robert H. Fiser, Jr., M.D., (Class of '66), a native of Morrilton and professor and chairman of Pediatrics in the UAMS College of Medicine, received "Distinguished Faculty Awards."

The award recipients were chosen by the Caduceus Club's Selection Committee, chaired by Arthur Squire, M.D., (Class of '68).

Specialty Meeting Notes

Arkansas Hand Club Notes

The Arkansas Hand Club met at Gaston's White River Resort on May 5-7, 1989. Dr. Bill Bowers from Richmond, Virginia, was the principal speaker. He is an orthopaedic surgeon whose primary interest is in the wrist, and more specifically in the distal radio-ulnar joint. However, he also has a special interest in the PIP joint, and he led a very sophisticated and enlightening discussion in these topics. Those present at the meeting were Ray Ashworth, M.D., Cole Goodman, M.D., James Moore, M.D.; Kenneth Rosenzweig, M.D.; Barry Thompson, M.D.; Peter Heinzelmann, M.D.; Alfred Hathcock, M.D.; John Smith, M.D.; Marcia Hixon, M.D.; Edward Weber, M.D.; and Brian Adams, M.D. The group met approximately from 1:00 p.m. until 6:00 p.m. on Friday and Saturday. There was an informal dinner gathering Friday and Saturday evenings. Those in attendance believe that it was one of the best meetings of the year.

A. B. Hathcock, M.D.

AMS NewsMakers

Bart Sills, M.D., and Gordon Sasser, M.D., are the new co-medical directors of the Crawford County Lodge in Mulberry. Both physicians are affiliated with the Holt-Krock Clinic in Alma and practice family medicine.

Clark M. Baker, M.D., a general practitioner in Paragould, has announced his retirement after 41 years of service. Dr. Baker was chief of staff for the Arkansas Methodist Hospital in 1955, 1960 and 1970.

The new vice-president of the Arkansas Chapter of the American Academy of Pediatrics is **Robert Glenn, M.D.** Dr. Glenn practices in Little Rock and was a member of the editorial board of the *Journal of the Arkansas Medical Society*.

William E. Golden, M.D., Director of the Division of General Internal Medicine at the University of Arkansas for Medical Sciences has been elected to the Council on Medical Education of the American Medical Association at this year's annual meeting in Chicago. This twelve-member AMA council advises the organization on all matters pertaining to medical education. It oversees AMA policies and activities in the accreditation of medical schools and residencies throughout the United States as well as the continuing medical education of practicing physicians and the development of allied health personnel.

The Arkansas Medical Society supported Dr. Golden's campaign. He has been a member of the AMS House of Delegates since 1985 and served a year on the Pulaski County Medical Society's executive committee. Dr. Golden is a Trustee of the American Society of Internal Medicine, a member of the editorial board of the *Journal of the Arkansas Medical Society* and has published many articles in the field of medical education.

The new officers of the Craighead-Poinsett County Medical Society are **Dr. David Pyle**, secretary-treasurer; **Dr. A.H. Rusher**, president-elect; and **Dr. Ray Hall, Jr.**, president. Drs. Pyle and Hall are internists, and Dr. Rusher is a general surgeon.

Guy Robinson, M.D., recently received the "Doctor of the Year" award from the Delta Memorial Hospital. Dr. Robinson has been in practice in Dumas as a family physician since 1948. In addition to his dedicated service as a physician, Dr. Robinson has been a 20-year member of the Dumas Public School Board of Education and 30-year member of both the Dumas Lions and the Dumas Chamber of Commerce.

Dr. Morriss M. Henry, a Fayetteville ophthalmologist, has been promoted to the rank of associate clinical professor at the University of Arkansas for Medical Sciences.



Warning: this pacifier can be hazardous to your baby's health.

If you won't stop smoking for your own good, do it for someone else's.

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The Christmas Seal People®

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NEW MEMBERS

BAXTER COUNTY MEDICAL SOCIETY

Landrum, William L., Diagnostic Radiology, Mountain Home. Born June 15, 1951, Abilene, TX. Pre-medical education, Texas Tech University, B.S., 1974. Medical education, Southwestern Medical School, Dallas, TX, 1979. Internship/residency, St. Paul Hospital, Dallas, TX. Fellowship, University of Utah, Salt Lake City, UT. Practice experience, 7 years, Diagnostic Images, Salt Lake City, UT; 2 years, Texas Tech University Health Sciences Center, Lubbock, TX. Teaching appointments, Assistant Professor, Texas Tech University. Board certified, Radiology. Member, RSNA, TMA.

CRITTENDEN COUNTY MEDICAL SOCIETY

Wah, John Chin, Family Practice, Marion. Born May 27, 1955, West Memphis. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1977. Medical education, University of Arkansas for Medical Sciences, 1982. Internship/Residency, Baylor College of Medicine, Houston. Practice experience, 2 years, Houston, TX; 5 months, West Memphis. Board certified, family practice. Member, AAFP.

OUACHITA COUNTY MEDICAL SOCIETY

Crump, Mark R., Family Practice, Camden. Born August 29, 1961, Shreveport, L.A. Pre-medical education, Louisiana State University, Shreveport, B.S., 1982. Medical education, LSU Medical Center, Shreveport, 1986. Internship/residency, St. Joseph Medical Center, Wichita, KS. Board eligible. Member, AAFP.

PULASKI COUNTY MEDICAL SOCIETY

Bienvenu, Gregory S., Nephrology, Internal Medicine, North Little Rock. Born January 25, 1953, Lafayette, LA. Pre-medical education, Louisiana State University and Southwestern Louisiana, B.S., 1977. Medical education, Louisiana State University, New Orleans, 1983. Internship/Residency, University Medical Center, Lafayette. Practice experience, Tulane Medical Center, New Orleans, Assistant Professor of Medicine. Board certified, internal medicine.

Church, Michael C., Internal Medicine, Little Rock. Born April 5, 1958. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1989. Medical education, UAMS, 1986. Internship/Residency, UAMS. Board eligible, internal medicine.

Deaton Jr., Charles W., Radiology, Little Rock. Born September 12, 1958, Booneville, MS. Pre-medical education, University of Mississippi, Jackson, B.A., 1980. Medical education, University of Mississippi Medical School, Jackson, 1984. Residency, University of Texas Southwest Medical School, Dallas. Fellowship, Neuroradiology, University of Texas Southwest Medical School. Practice experience, 4 years, University of Texas Medical School, Dallas; 2 months, Armed Forces Institute of Pathology, Washington, D.C.; 1 year, Parkland Memorial Hospital, Dallas. Board certified, radiology.

DeLoach Jr., John M., General Surgery, North Little Rock. Born November 19, 1956, Magnolia. Pre-medical education, Louisiana State University, Baton Rouge; Southern Arkansas University, Magnolia, B.A., 1979. Medical education, UAMS, 1983. Internship/residency, UAMS; Waterbury Hospital Health Center, Waterbury, CT.

Evans, Scott J. J., Radiology, Little Rock. Born March 9, 1957, Salt Lake City, UT. Pre-medical education, University of Utah, Salt Lake City, UT, B.A. Medical education, University of Utah, 1984. Residency, Mallinckrodt Institute of Radiology. Fellowship, University of California, San Francisco. Practice experience, University of California, San Francisco, San Francisco General Hospital; Mallinckrodt Institute of Radiology, St. Louis, MO. Board certified, radiology.

Meziere, Tom L., Gastroenterology, Little Rock. Born September 12, 1957, Oklahoma City, OK. Pre-medical education, University of Oklahoma, Norman, B.S., 1980. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1984. Internship/residency, Arizona Health Sciences Center, Phoenix, AZ. Fellowship, University of Oklahoma for Health Sciences, Oklahoma City. Board certified, Internal Medicine.

Watson, Daniel W., Family Practice, Little Rock. Born May 15, 1958, Little Rock. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1980. Medical education, UAMS, 1985. Internship, UAMS. Residency, UAMS AHEC Northeast, Jonesboro.

Williamson, Stephen E., General Surgery, Little Rock. Born June 13, 1958, Stillwater, OK. Pre-medical education, Hendrix College, Conway, B.A., 1980. Medical education, UAMS, 1984. Internship/Residency, Huron Road Hospital, East Cleveland, OH.

RESIDENT SECTION

Adkins, James K., Family Practice. Born August 23, 1955, Blytheville. Pre-medical education, Arkansas State University, Jonesboro, B.S., 1984. Medical education UAMS, 1988. Internship/Residency, AHEC, Jonesboro.

Akins, Victoria, Family Medicine. Born August 6, 1962, Parkdale, AR. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1984. Medical education,

UAMS, 1989. Residency, UAMS.

Anzalone, Gary P., Pathology. Born December 6, 1963, Monroe, LA. Pre-medical education, Northeast Louisiana University, Monroe, B.S., 1985. Medical education, Louisiana State University Medical Center, Shreveport, 1989. Residency, UAMS.

Barnes, Gregory, F., Obstetrics/gynecology. Born July 1, 1963, Joliet, IL. Pre-medical education, University of Central Arkansas, Conway. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Bauer, David H. Born August 23, 1963, Little Rock. Pre-medical education, Vanderbilt University, Nashville, 1985. Medical education, Vanderbilt University, 1989.

Beaverson, Anthony B., Emergency medicine. Born March 3, 1962, Hot Springs. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1984. Medical education, UAMS, 1989. Residency, UAMS.

Beasley, John G., Urology. Born May 17, 1961, Bennettsville, SC. Pre-medical education, University of South Carolina, Columbia, B.A., 1983. Medical education, Medical University of South Carolina, Charleston, 1989. Internship/Residency, UAMS.

Beaton, Susan R., Pediatrics. Born November 17, 1962, Arkansas. Pre-medical education, Hendrix College, Conway, B.S., 1985. Medical education, UAMS, 1989. Residency, UAMS.

Beck, Perry M. Born April 25, 1964, Dallas, TX. Pre-medical education, Texas A & M University, College Station, B.S., 1985. Medical education, University of Texas, Southwestern, Dallas, 1989. Internship, UAMS.

Beene, Stephen M., Internal medicine. Born October 27, 1953, Kansas City, KS. Pre-medical education, Louisiana State University, Shreveport. Medical education, LSU Medical Center, Shreveport, 1989. Internship/ Residency, UAMS.

Bivins Jr., Franklin G., Family Practice. Born April 30, 1959, Little Rock. Pre-medical education, University of Arkansas, Little Rock, B.S., 1982. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Blair, Susan D., Ophthalmology. Born August 10, 1958, El Dorado. Pre-medical education, Oklahoma State University, A.D.N., 1982 and University of Arkansas, Fayetteville, B.S., 1984. Medical education, UAMS, 1989. Internship, UAMS. Residency, Georgetown University, Washington, D.C.

Blaisdell, Greg D., Psychiatry. Born January 29, 1961, Fort Worth, TX. Pre-medical education, Trinity University, San Antonio, B.S., 1983; T.C.U, M.S., 1985. Medical education, University of Texas Health Sciences Center, San Antonio, 1989. Residency, UAMS.

Bohle, David J. Born March 7, 1959, Baltimore, MD. Pre-medical education, University of Maryland, B.A., 1981. Medical education, University of Texas, San Antonio, 1989. Internship, UAMS.

Bonner, Mark A., Family Practice. Born February 13, 1961, Little Rock. Pre-medical education, University of Arkansas, 1982. Medical education, UAMS, 1987. Internship/Residency, UAMS; AHEC, Northwest.

Bonner, Cynthia M. Born June 19, 1963, Tuscaloosa, AL. Pre-medical education, University of Alabama, Tuscaloosa, 1986. Medical education, University of Alabama, Birmingham, 1989. Internship, UAMS.

Bowman, Gary W., Family Practice. Born April 11, 1958, California. Pre-medical education, University of Arkansas, Little Rock, B.S. Medical education, Oklahoma State University, Tulsa, 1989.

Boyd, Anita L. Born August 8, 1961, Little Rock. Pre-medical education, University of Central Arkansas, Conway, B.S.E., 1983. Medical education, UAMS, 1989. Internship, UAMS.

Brand, Robert L. Born March 5, 1963, Jonesboro. Pre-medical education, University of Arkansas, Fayetteville, 1985. Medical education, UAMS, 1989. Internship, UAMS.

Brooks, Andrew T. Born June 8, 1959, Indianapolis, IN. Pre-medical education, University of California, Berkeley, B.A., 1982. Medical education, University of Oklahoma, Oklahoma City, 1989.

Brooks, David W. Born October 3, 1959, Little Rock. Pre-medical education, University of Arkansas, Little Rock, B.A., 1982. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Bryles, Jeffrey S. Born April 15, 1962, Pine Bluff. Pre-medical education, University of Arkansas, Little Rock, B.S., 1984. Medical education, UAMS, 1989. Internship, UAMS.

Burch, Mary J., Family Medicine. Born February 16, 1962, Russellville. Pre-medical education, Arkansas Tech University, B.S., 1984. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Callaway, Michael W., Family Medicine. Born May 23, 1963, Little Rock. Pre-medical education, University of Arkansas, Fayetteville, B.A., 1985. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Carney, Stephen E., Family Practice. Born June 30, 1960, Memphis, TN. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1983. Medical education, UAMS, 1988. Internship/Residency, UAMS.

Carter, Timothy C. Born March 27, 1963, Little Rock. Pre-medical education, Rhodes College, Memphis, 1985. Medical education, UAMS, 1989. Internship, UAMS.

Casey, Jason R., Internal Medicine. Born July 5, 1960, Memphis, TN. Pre-medical education, Arkansas State University, Jonesboro, B.S., 1983. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Champlin, Terence L. Born July 22, 1960, Harrison. Pre-medical education, Southwest Baptist University, Bolivar, MD, B.S. 1985. Medical education, UAMS, 1989. Internship, UAMS.

Collins, Curtis L., Pathology. Born May 19, 1961, Jackson, MS. Pre-medical education, University of

Mississippi, Oxford, B.A., 1983. Medical education, University of Mississippi, Jackson, 1988. Internship, Madisonville, KY. Residency, UAMS.

Cook, James M., Vascular Surgery. Born December 14, 1955, Memphis. Pre-medical education, Baylor University, Waco, B.S., 1977. Medical education, University of Texas Southwestern, Dallas, 1981. Internship/Residency, University of Utah Medical Center, Salt lake City. Fellowship, UAMS.

Courtney Jr., Willis, Neurology. Born January 17, 1961, Watson. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1984. Medical education, UAMS, 1988. Internship, Emory University Hospital, Atlanta, GA. Residency, UAMS.

Crouch Jr., James R., Family Medicine. Born November 17, 1961, Lufkin, TX. Pre-medical education, Arkansas Tech University, B.S., 1984. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Crowe, Michael J. Born January 9, 1962, Newark, NJ. Pre-medical education, University of California, Los Angeles, B.S., 1984. Medical education, University of Southern California School of Medicine, 1989. Internship, UAMS.

Elliott, Denise A. Born September 17, 1963, De-Queen. Pre-medical education, Ouachita Baptist University, Arkadelphia, B.S., 1985. Medical education, UAMS, 1989.

Erickson, Stephen A., Pathology. Born July 16, 1989, Cedar Rapids, IA. Pre-medical education, Hendrix College, B.A., 1989. Medical education, UAMS, 1989. Internship, UAMS.

Farmer, Charles E., Pathology. Born April 12, 1962, Little Rock. Pre-medical education, Mississippi College, Clinton, B.S., 1984. Medical education, University of Mississippi Medical Center, Jackson, 1988. Internship, Cataway Methodist Medical Center, Birmingham, AL. Residency, UAMS.

Forte, Kevin F., Orthopaedics. Born September 15, 1960, Lake Village, AR. Pre-medical education, University of Arkansas, Fayetteville, 1983. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Foster, Gil C., Family Medicine. Born July 19, 1962, Fort Smith. Pre-medical education, Harding University, Searcy, B.S., 1984. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Griffith, Patrick D., Surgery. Born January 26, 1965, Kansas City, MO. Pre-medical education, University of Missouri, Kansas City, B.A., 1989. Medical education, University of Missouri, Kansas City, 1989. Residency, UAMS.

Grimes, Kimberly A., Radiation Oncology. Born May 3, 1962, Columbus, GA. Pre-medical education, University of Arkansas, Little Rock, B.S., B.A., 1984. Medical education, UAMS, 1989. Internship, UAMS. Residency, University of Louisville.

Grisham, Dannetta, Emergency Medicine. Born May 30, 1963, Dallas, TX. Pre-medical education, Hendrix College, Conway, B.A., 1985. Medical education, UAMS, 1989. Residency, UAMS.

Guresky, Peter W. Born March 10, 1958, Moultrie, GA. Pre-medical education, University of Arkansas, Little Rock, B.S., 1982. Medical education, UAMS, 1989. Internship, UAMS.

Hairston, Roger K., Pathology. Born April 22, 1959, Little Rock. Pre-medical education, University of Arkansas, Little Rock, B.A., 1984. Medical education, UAMS, 1989. Residency, UAMS.

Harris, Russell D., Pediatrics and Anesthesiology. Born May 7, 1961, Arlington, TX. Pre-medical education, University of Texas, Arlington, 1983. Medical education, University of Texas Medical Branch, Galveston, 1987. Internship/Residency, University of Texas Medical Branch, Galveston. Residency, UAMS.

Hedberg, Curtis L. Born May 11, 1962, Kansas City, MO. Pre-medical education, St. Louis University, St. Louis, MO, B.S., 1984. Medical education, University of Missouri, Columbia, 1989. Internship, UAMS.

Hinkle, Mareus E., Family Practice. Born March 13, 1958, Galveston, TX. Pre-medical education, Texas A & M University, College Station. Medical education, Universidad Technologia de Santiago, Santo Domingo, Dominican Republic, 1987. Residency, UAMS.

Hitt Jr., Wilber C., Obstetrics and Gynecology. Born April 29, 1963, Valpraiso, IN. Pre-medical education, Ouachita Baptist University, Arkadelphia, B.S., 1985. Medical education, UAMS, 1989. Residency, UAMS.

Hoke, Wallace S., Family Medicine. Born September 4, 1961, Memphis, TN. Pre-medical education, Hendrix College, Conway, B.A., 1983. Medical education, UAMS, 1987. Residency, UAMS AHEC Pine Bluff.

Hollis, Roland D. Born August 17, 1961, Jonesboro. Pre-medical education, Arkansas State University, Jonesboro, B.S., 1983. Medical education, UAMS, 1989. Internship, UAMS AHEC Pine Bluff.

Hopkins Jr., Robert H. Born April 28, 1962, Batesville. Pre-medical education, Davidson College, Davidson, NC, B.S., 1984. Medical education, Medical College of Georgia, Augusta, 1989. Internship, UAMS.

Houston, Samuel T., Urology. Born March 12, 1954, Woodland, CA. Pre-medical education, University of California, Davis, B.S., 1977. M.D., 1982. Internship, Huntington Memorial Hospital, Pasadena, CA. Residency, University of Cincinnati. Fellowship, Albert Einstein Division of Urology, University of California, Los Angeles.

Hunter, Maya K., Pediatrics. Born November 17, 1961, Berkeley, CA. Pre-medical education, Hendrix College, Conway, B.A., 1989. Medical education, UAMS, 1989. Residency, UAMS.

Hudome, Susan M., Pediatrics. Born September 30, 1962, Bryn Mawr, PA. Pre-medical education, St.

Joseph's University, Philadelphia, B.S., 1984. Medical education, Pennsylvania State University, Hershey, PA, 1988. Internship, Duke University, Durham, NC. Residency, UAMS/Arkansas Children's Hospital.

Hulsey, Matthew D. Born May 21, 1961, Ironton, MO. Pre-medical education, Westminster College, Fulton, 1983. Medical education, University of Health Sciences and College of Osteopathic Medicine, Kansas City, MO, 1988. Internship, Charles E. Still Osteopathic Hospital, Jefferson City, MO.

Hurlbut, Kevin M., Rehabilitative Medicine. Born March 31, 1962, Topeka, KS. Pre-medical education, Kansas State University, Manhattan, B.S., 1984. Medical education, University of Kansas School of Medicine, Kansas City, 1989. Internship/Residency, UAMS.

Ingram, Jim M., Pediatrics. Born October 20, 1962, Little Rock. Pre-medical education, Hendrix College, Conway, B.S., 1985. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Jeffery, James C., Surgery. Born December 22, 1962, Lake Charles, LA. Pre-medical education, Louisiana Tech University, Ruston, B.S., 1985. Medical education, Louisiana State University Medical Center, Shreveport, 1989. Internship, UAMS.

Jensen, Joseph C., Surgery. Born November 30, 1959, Milwaukee WI. Pre-medical education, Memphis State University. Medical education, University of Tennessee, Memphis, 1989. Internship, UAMS.

Jones, Stacie M. Born March 5, 1962, Little Rock. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1984. Medical education, UAMS, 1989. Internship, UAMS.

Karing, Michael V. Born September 25, 1961, Anchorage, AK. Pre-medical education, University of Texas, Austin, B.S., 1984. Medical education, University of Texas Medical Branch, Galveston, 1989. Internship, UAMS.

Kelley, Manuel. Born June 23, 1948. Pre-medical education, Pine Bluff, B.S., 1920. Medical education, University of Colorado, Denver, 1970. Internship, Presbyterian Hospital, Denver, CO.

Kent, William C., Family Medicine. Born August 6, 1949, Newport, AR. Pre-medical education, Arkansas College, Batesville, B.A.; UAMS, M.S. Medical education, UAMS, 1989. Internship/Residency, AHEC-Northeast, Jonesboro.

Keppler-Noreuil, Kim M., Pediatrics. Born November 12, 1962, Joliet, IL. Pre-medical education, Grinnell College, Grinnell, IA, B.A., 1984. Medical education, Southern Illinois University, Springfield, 1989. Internship/Residency, UAMS.

Kerns, Kelly L., Anesthesiology. Born February 16, 1961, Washington, D.C. Pre-medical education, Henderson State University, Arkadelphia, 1983. Medical education, UAMS, 1989. Internship, UAMS (Housestaff). Residency, Vanderbilt University, Nashville, TN.

Krajca-Radcliffe, Joan B. Born August 10, 1952, Albany, NY. Pre-medical education, Cornell University, Ithaca, NY, B.S. 1973. Medical education, University of Texas Medical Branch, Galveston, 1989. Internship, UAMS.

Lipe, Carol A., Pediatrics. Born November 26, 1962, Little Rock. Pre-medical education, Hendrix College, Conway, B.A., 1981. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Love, Jon C., Pediatrics. Born June 23, 1962, Eugene, OR. Pre-medical education, Abilene Christian University, Abilene, TX, B.S., 1985. Medical education, Texas Tech Health Sciences Center, Lubbock, 1989. Residency, UAMS.

Martin, Marian, Pediatrics. Born December 11, 1962, Winston Salem, NC. Pre-medical education, Presbyterian College, Clinton, SC, B.A., B.S., 1985. Medical education, Medical College of Georgia, Augusta, 1989. Internship/Residency, UAMS.

McBee, Sara E. Born August 20, 1943, Maquokela, IA. Pre-medical education, University of Arkansas, B.A., 1981. Medical education, Oklahoma College of Osteopathic Medicine, D.O., 1986. Internship, Oklahoma Oseteopathic Hospital, Tulsa. Residency, AHEC - Northwest, Fayetteville.

McGuff, Miles D., Emergency Medicine. Born January 17, 1962, Charlotte, NC. Pre-medical education, St. Mary's University, San Antonio, B.S., 1984. Medical education, University of Texas Medical School, San Antonio, 1989. Residency, UAMS.

Meyer, Lawrence H., Anesthesiology. Born March 22, 1961, IN. Pre-medical education, Hendrix College, Conway, B.A., 1985. Medical education, UAMS, 1989. Internship, UAMS.

Montgomery, Lori E. Born October 27, 1961, Dallas. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1983. Medical education, UAMS, 1989. Internship, UAMS.

Moore, Donald J., Pediatrics. Born January 15, 1962, Camden, AR. Pre-medical education, Ouachita Baptist University, Arkadelphia, B.S., 1984. Medical education, UAMS, 1988. Internship, University of Oklahoma, Oklahoma City. Residency, UAMS.

Moskovich, Arlene S., Family Medicine. Born April 1, 1937, Etna, PA. Pre-medical education, Duquesne University, Pittsburgh, PA, B.S., 1959; West Virginia University, Morgantown, Ph.D. Medical School, Ross University, Dominica, West Indies, 1987. Residency, UAMS.

Mullens, Mark L. Born July 17, 1961, Crossett, AR. Pre-medical education, Birmingham Southern College, Birmingham, AL, B.A., 1985. Medical education, University of Alabama School of Medicine, 1989. Internship, UAMS.

Nolan, Kirkland C. Born September 27, 1961, Seminole, OK. Pre-medical education, Oklahoma State

University, Stillwell, B.S., 1984. Medical education, University of Oklahoma, Tulsa, 1989. Internship, UAMS.

Noreuil, Todd O. Born May 21, 1963, Springfield, IL. Pre-medical education, Southern Illinois University, Carbondale, B.A., 1985. Medical education, Southern Illinois University, Springfield, 1989. Internship, UAMS.

Otovo, Earnestine W., Psychiatry. Born March 11, 1949, Pine Bluff. Pre-medical education, Stillman College, Tuscaloosa, AL, B.S. Medical education, University of California, San Francisco, 1979. Internship/Residency, UAMS.

Padilla, Rafael E., Anesthesiology. Born January 28, 1962, Youngstown, OH. Pre-medical education, Cornell University, B.S., Medical education, Brown University, 1988. Internship/Residency, UAMS.

Parro, Elizabeth A. Born December 20, 1963, Thibodaux, LA. Pre-medical education, Louisiana State University, Baton Rouge, 1985. Medical education, Louisiana State University Medical Center, New Orleans, 1989. Internship, UAMS.

Petty, Jay E. Born January 25, 1962, Fort Worth. Pre-medical education, University of Arkansas, Little Rock, B.S., 1983. Medical education, UAMS. Internship, AHEC - Southwest.

Phillips, Laura G., Pediatrics. Born July 15, 1963, Athens, GA. Pre-medical education, Furman University, Greenville, SC., B.S., 1985. Medical education, University of South Carolina, 1989. Residency, UAMS.

Pippenger, Janet C., Pediatrics. Born August 31, 1963, Jonesboro. Pre-medical education, Arkansas State University, Jonesboro, B.S., 1985. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Plott, R. Todd, Dermatology. Born December 16, 1961, Lubbock, TX. Pre-medical education, Southern Nazarene University, Bethany, OK, B.S., 1984. Medical education, University of Texas Medical Branch, Galveston, 1989. Internship/Residency, UAMS.

Poole, Charles T. Born November 8, 1961, Hot Springs. Pre-medical education, Hendrix College, Conway, 1984. Medical education, UAMS, 1989.

Porter, Martin D., Anesthesiology. Born June 2, 1961, Millington, TN. Pre-medical education, University of Arkansas, Little Rock, B.S., 1984. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Porter, Maria C. Born January 8, 1989, Monterrey, Nuevo Leon, Mexico. Pre-medical education, University of Nuevo Leon, Monterrey, Nuevo Leon, Mexico, B.S., 1976. Medical education, University of Nuevo Leon, Monterrey, Nuevo Leon, Mexico, 1983.

Price, Claire B., Ophthalmology. Born August 30, 1963, Lake Village, AR. Pre-medical education, Northeast Louisiana University, Monroe, 1985. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Pruitt, Tad C., Orthopaedics. Born July 24, 1964, Fort Worth, TX. Pre-medical education, Texas A & M University, College Station, B.S., 1987. Medical education, Texas A & M University College of Medicine, College Station/Temple, TX, 1989. Internship/Residency, UAMS.

Reese, John L. Born October 13, 1963, Metairie, LA. Pre-medical education, Louisiana State University, Baton Rouge, B.S., 1985. Medical education, Louisiana State University Medical Center, New Orleans, 1984. Internship, UAMS.

Reinhart, Jeffrey H., Family Medicine. Born December 10, 1961, Monticello. Pre-medical education, University of Arkansas, Monticello, B.S., 1985. Medical education, UAMS, 1989. Residency, UAMS.

Reis, Ivory A. Born January 28, 1955, Ormskirk, England. Pre-medical education, University of Arkansas, Little Rock. Medical education, UAMS, 1989. Internship, UAMS.

Ricker, Jonathan E., Pediatrics. Born April 29, 1963, Norwich, CT. Pre-medical education, Southern Methodist University, Dallas, B.S., 1985. Medical education, University of Texas Southwestern, Dallas, 1989. Internship/Residency, UAMS.

Ringold, Mark A. Born December 5, 1961, Danville, IL. Pre-medical education, Freed-Hardeman College, Henderson, TN, B.S., 1984. Internship, UAMS.

Robbins, Mark B., Radiology. Born May 4, 1960, Searcy. Pre-medical education, University of Arkansas, Fayetteville, M.S., 1982. Medical education, UAMS, 1987. Internship, St. Joseph's Hospital, Milwaukee, WI. Residency, UAMS.

Roberts, Kevin D., Family Medicine. Born July 3, 1963, Little Rock. Pre-medical education, University of Arkansas, B.S., 1985. Medical education, UAMS, 1989.

Robertson, Ronald D. Born March 30, 1960, Kansas City, MO. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1983. Medical education, UAMS, 1989. Internship, UAMS.

Roman, Anthony M., Emergency Medicine. Born June 11, 1955, Dallas, TX. Pre-medical education, University of Texas, Austin, B.A., 1978. Medical education, Creighton University School of Medicine, Omaha, NE, 1986. Internship/Residency, John Peter Smith, Fort Worth, TX. Residency, UAMS.

Rozas, David R., Ophthalmology. Born October 27, 1963, Eunice, LA. Pre-medical education, Louisiana State University, Baton Rouge. Medical education, Louisiana State University Medical Center, Shreveport, 1989. Internship, UAMS.

Sessions II, Louis W., Anesthesiology. Born October 28, 1953, Shreveport, LA. Pre-medical education, Louisiana Tech University, Ruston, B.S., 1975. Medical education, Louisiana State University, Shreveport, 1979. Internship/Residency, UAMS.

Sharkey Jr., Paul C., Pediatrics. Born August 15, 1962, Houston, TX. Pre-medical education, Baylor University, Waco, B.S., 1984. Medical education, University of Texas Medical Branch, Galveston, 1989.

Internship/Residency, UAMS.

Sharp, Jan C., General Surgery. Born June 9, 1963, Arkansas City, KS. Pre-medical education, University of Central Arkansas, Conway, B.S., 1984. Medical education, UAMS, 1989.

Shepard, Shelley M., Obstetrics and Gynecology. Born February 7, 1963, Clay Center, KS. Pre-medical education, Pittsburg State University, Pittsburg, KS, B.A., 1984. Medical education, University of Kansas, Kansas City, KS, 1989. Residency, UAMS.

Sherwood, Gary E., Emergency Medicine. Born December 31, 1958, Mesa, AZ. Pre-medical education, University of Central Arkansas, Conway, B.S., 1985. Medical education, UAMS, 1989. Residency, UAMS.

Skidmore, Grant A. Born September 2, 1963. Pre-medical education, Harding University, Searcy. Medical education, UAMS, 1989. Internship, UAMS.

Smith III, Eugene S., Cardiology. Born May 22, 1960, Dallas, TX. Pre-medical education, Harding University, Searcy, B.S., 1987. Medical education, University of Texas Southwestern, Dallas, 1986. Internship/Residency, Presbyterian Hospital, Dallas. Fellowship, UAMS.

Smith, Shannon G., Internal Medicine. Born September 7, 1963, Fayetteville. Pre-medical education, Hendrix College, Conway, B.A., 1985. Medical education, UAMS, 1989. Internship, UAMS.

Stubblefield, Sandra C., Family Practice. Born December 21, 1959, Jonesboro. Pre-medical education, Arkansas State University, B.S., 1982. Medical education, UAMS, 1988. Internship/Residency, UAMS.

Stubblefield, William S., Family Practice. Born June 6, 1960, Blytheville. Pre-medical education, Arkansas State University, Jonesboro, 1981. Medical education, UAMS, 1989. Residency, UAMS.

Sullivan, Brian R. Born April 2, 1963, Tulsa, OK. Pre-medical education, Rice University, Houston, B.A., 1985. Medical education, University of Texas, Houston, 1989. Internship, UAMS.

Thomas, Stuart N., Otolaryngology. Born January 22, 1963, Philadelphia, PA. Pre-medical education, University of Texas, Austin, B.A., 1985. Medical education, University of Texas Southwestern, Dallas, 1989. Internship/Residency, UAMS.

Thompson, Joseph W. Born June 30, 1963, Conway. Pre-medical education, Hendrix College, Conway, 1984. Medical education, UAMS, 1989. Internship, Arkansas Children's Hospital (Housestaff).

Tilley, Absalom H. Born December 25, 1961, Harrison. Pre-medical education, University of Arkansas, Fayetteville, B.A., 1984. Medical education, UAMS, 1989. Internship/Residency, UAMS.

Triplett, Richard D., Medicine. Born July 15, 1960, Houston. Pre-medical education, Baylor University, Waco, B.A., 1982. Medical education, American University School of Medicine, British West Indies, 1987. Internship, Mount Vernon Hospital, New York Medical College. Residency, University of Virginia, Roanoke.

Van Hemert, Rudy L., Radiology. Born June 20, 1964, Oakland, CA. Pre-medical education, University of New Mexico, Albuquerque. Medical education, University of New Mexico, 1989. Residency, UAMS.

Vice, Mark A., Family Medicine. Born October 3, 1961, Benton. Pre-medical education, University of Arkansas, Little Rock, B.A., 1984. Medical education, UAMS, 1989. Internship, AHEC Pine Bluff.

Washington, Mitzi A. Born February 12, 1962, Searcy. Pre-medical education, Hendrix College, Conway, B.A., 1984. Medical education, UAMS, 1989.

Whitfield, Cindy G., Family Medicine. Born March 29, 1961, Searcy. Pre-medical education, Harding University, Searcy, B.S., 1984. Medical education, UAMS, 1989. Internship/Residency, UAMS.

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IN MEMORIAM

WILLIAM R. COTHERN, M.D.

Dr. William R. Cothern, of Memphis, TN, formerly a Crossett general practitioner, died July 8, 1989. He was 71.

Dr. Cothern was a 1944 graduate of the University of Arkansas for Medical Sciences. He was a member of the Ashley County Medical Society and the AMA. Dr. Cothern was a Life Member of the Arkansas Medical Society.

BOB G. BANISTER, M.D.

Dr. Bob G. Banister, a Conway family practitioner, died July 9, 1989. He was 57.

Dr. Banister was the Faulkner County coroner for 25 years, served as team physician for the University of Central Arkansas and Hendrix College and was active on the Conway Public School board and the Conway Regional Hospital board. He began practice in Conway in 1960. He was a member of the state Board of Health as well as a member of the Arkansas State Hospital Board, the Statewide Health Coordinating Council and the Central Arkansas Health Systems Agency Board and Executive Committee.

Dr. Banister was a member of the Arkansas Medical Society, the American Medical Association, and the Faulkner County Medical Society. He was a member, deacon, and trustee of First Baptist Church.

Survivors are his wife, Janis Purtle Banister; two sons, Dr. Robert Bradley Banister of Conway and William Brian Banister of Pittsburgh; a daughter, Barbara Anne Banister of Conway; a sister, Mrs. Marvin Houston of Forrest City; and a grandchild.

Memorials honoring Arkansas Medical Society members and their spouses can be made to the Medical Education Foundation for Arkansas (MEFFA), Post Office Box 5776, Little Rock, AR 72215. Call the Society for information.



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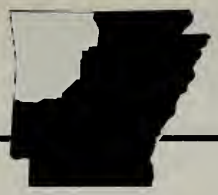
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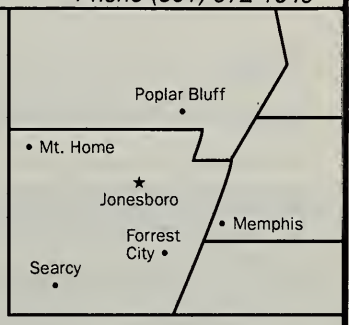
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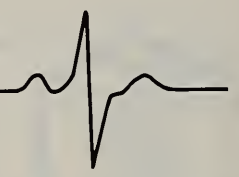
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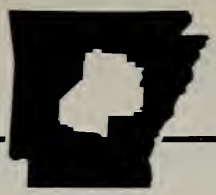
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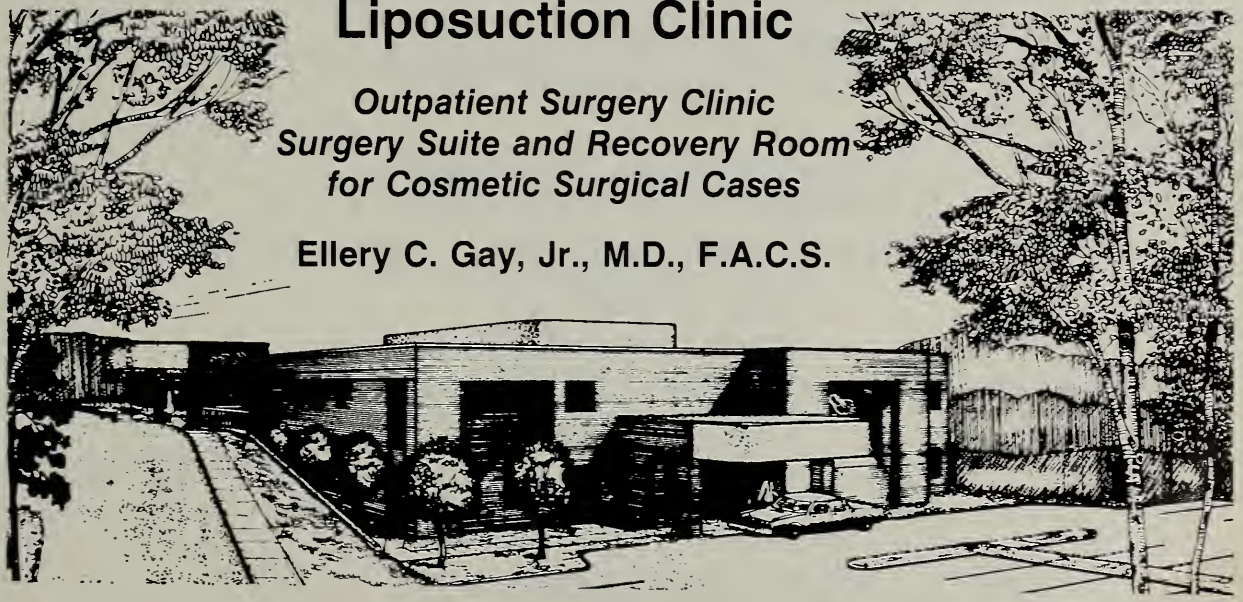
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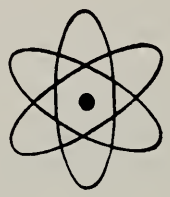
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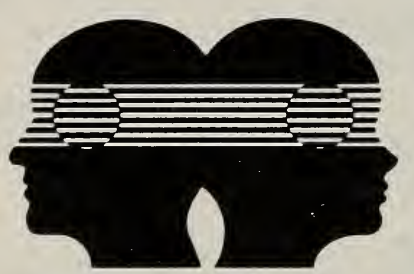
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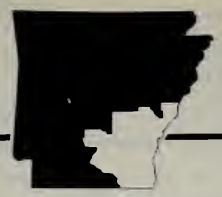
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Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects*.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions*.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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On Our Cover: The photo is of Pealargonium sp. *or geranium pollen. It was magnified approximately 775x. with an electron microscope. The photographer is Tyrrel Grohman, M.D., a radiology resident at UAMS.*

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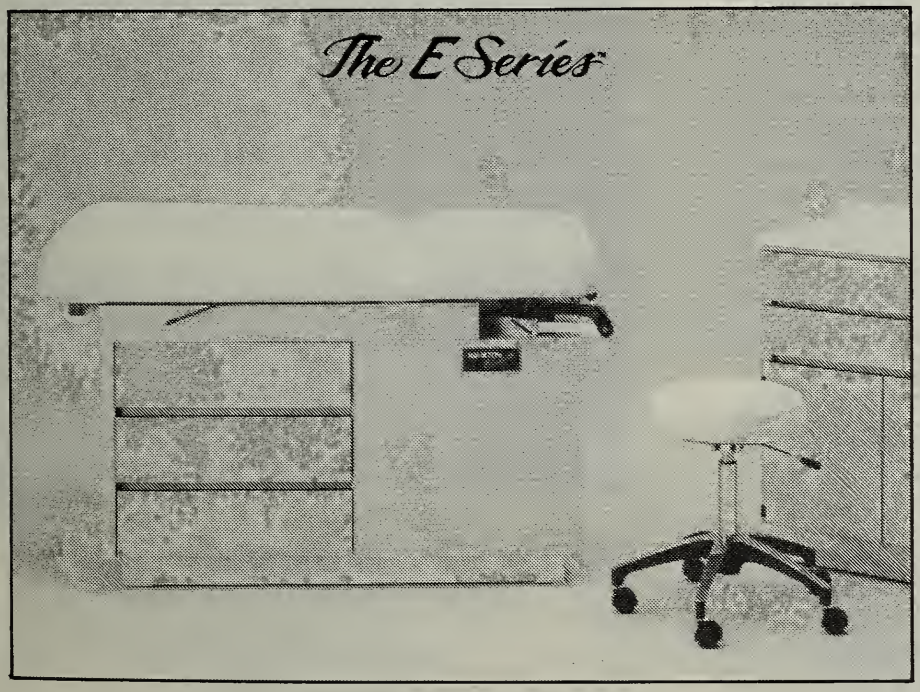
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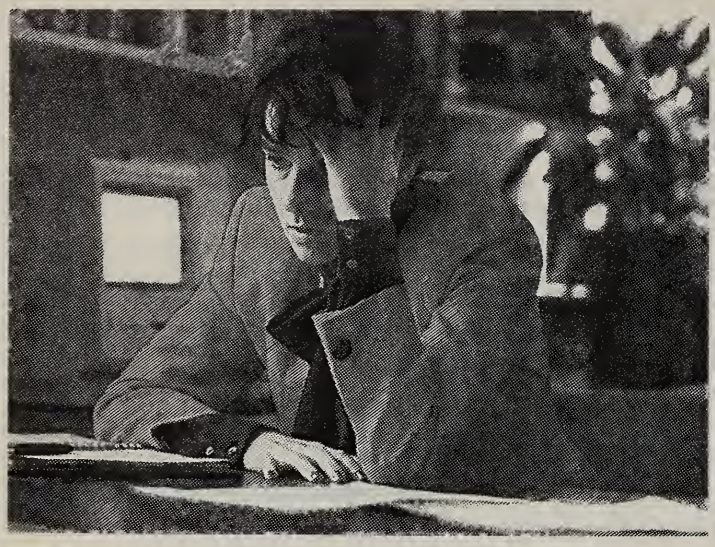
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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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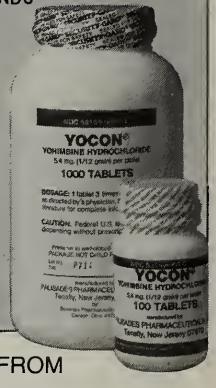
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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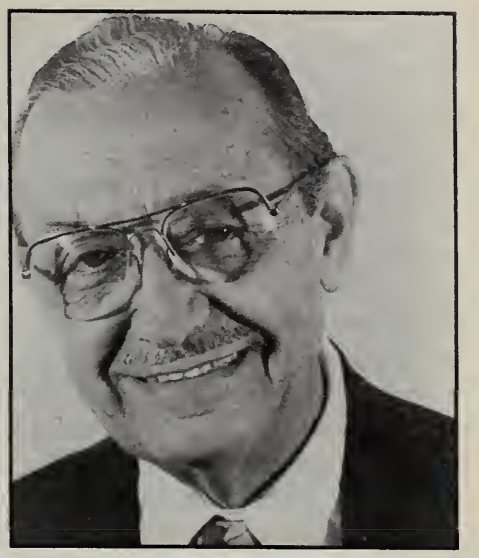
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EDITORIAL



The Physician and Mental Retardation

Ben N. Saltzman, M.D.

In the year 1946, six years after graduating from the University of Oregon School of Medicine in Portland, I found myself in a solo general practice in Mountain Home, Arkansas. An internship, residency and four years of military service, primarily caring for civilians in the Panama Canal Zone provided a fairly good basis for primary care in my new community. However, I was soon confronted with a problem for which I had practically no preparation: the responsibility of providing care to several children who had been diagnosed as being mentally retarded.

Up to that time, before the advent of the antibiotic era, children of that type died at a fairly young age. Physicians were held responsible for the prevention as well as the treatment of serious illness in these young patients. Medical school curricula in those days did not include special courses for dealing with health problems of the retarded. Those children were still being classified as morons, imbeciles, idiots and mongoloids. The literature at that time was also of little help.

Local services were not available in rural areas of the state. Referrals were often made to larger cities, usually far distant from the home communities. Parents would reluctantly take their children to St. Louis, Dallas, Memphis and as far away as Chicago, only to return home with them, unhappy and totally dissatisfied.

Although the family doctor or general practitioner was the first physician to see the child and to make the diagnosis, he was completely unprepared to know how to deal with the case. Often the first recommendation was to tell the parent that the child needed to be institutionalized.

Parents recognized that something needed to be done. They needed help. They began to form groups and associations and by banding together became effective in seeking solutions for care and prevention.

Chance has a peculiar way of working its way into the lives and behavior of individuals. In the year 1956, I became vice-president of the Arkansas State Elks Association and was asked to come up with a project with which the Elks could become identified on a continuing basis. At the same time, the state legislature, at the instigation of Governor Orval Faubus, had approved the funding for construction of a "Children's Colony" in Conway, Arkansas for the state's mentally retarded children. The superintendent of the future colony was traveling over the state to gain support for the project and met with me. We determined that the Elks could be most helpful by providing recreational equipment as well as workshop supplies on an on-going basis, year after year.

Because of my interest a voluntary association known as the Arkansas Association for Retarded Children invited me into membership. This was my opportunity to learn more about the problem as well as to seek solutions. In a short period of time, probably because it was unusual for a physician who was not a parent of a retarded child to take an interest, I was elected president of the organization. Later, I served on the National Board as a director and a regional vice-president.

It was in this latter capacity that my knowledge of mental retardation increased considerably. I met many leading physicians and psychologists who believed that physicians had a great responsibility in this field. I will not go into detail concerning the differing ideas that were being expressed for the management of the mentally retarded individual. However, there was a general agreement that the large institutions for the warehousing of individuals should be phased out and smaller units providing a home-like atmosphere be provided and attention leading to "mainstreaming" and "community living" become the order of the day.

Over the years many changes have taken place. Increasing emphasis has been placed upon the importance of education of the primary physician in mental retardation. Many pamphlets and books have been published by the American Medical Association, all emphasizing the need for physician education. Several years ago, I represented the National Association for Retarded Citizens as a member of a National Advisory Committee related to the Training of Physicians in Developmental Diagnosis. The first meeting

was held in Denver, Colorado, at the John F. Kennedy Child Development Center. Dr. William K. Frankenburg of the University of Colorado Medical Center was our mentor. He stressed the fact that physicians could be better trained to make necessary diagnosis without complete multidisciplinary evaluation. His aim was to develop a "concise, economical program that could be replicated nationwide utilizing videotape and print media in instructional materials." He postulated four functions for the primary care physician: making a categorical diagnosis, determining if referral is necessary, assembling of test results into a comprehensive plan, and counseling with families.

Dr. Frankenburg planned to accomplish his physician training program by utilizing the University Affiliated Programs that were beginning to spring up over the country. Arkansas was the 36th state to develop a UAP or UAF as it is now called. The consortium here consists of the University of Arkansas at Fayetteville, Little Rock, Pine Bluff and the University of Arkansas for Medical Sciences in Little Rock. At present 45 pediatric residents are rotating through the Dennis Development Center in Little Rock, studying psychological evaluation tools. Their next rotation will deal with screenings and diagnosis.

Interest in the retarded individual is growing. The retarded are living longer, becoming better educated, gaining effective employment and becoming useful citizens. The physician can help parents make an informed decision. The physician with an interest in MR can help educate other physicians and can take advantage of continuing education courses. We have a duty to ensure that the retarded get the best possible early start in life so that they can live up to their full potential.

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AMS Special Committee on AIDS

William N. Jones, M.D., Chairman

Update September 1989: Guidelines for Prophylaxis Against *Pneumocystis carinni* Pneumonia for Persons Infected with Human Immunodeficiency Virus

Pneumocystis carinii *pneumonia (PCP), the most common presenting manifestation of the acquired immunodeficiency syndrome (AIDS), is a major and recurring cause of morbidity and mortality for persons infected with the human immunodeficiency virus (HIV). In recent years, important advances have been made in understanding which patient subpopulations are at highest risk for developing PCP and in the design of chemotherapeutic regimens that can reduce the frequency of this illness. Recently, a number of experts* convened by the National Institutes of Health independently reviewed data on prophylaxis against PCP among persons infected with HIV, and then provided recommendations to the U. S. Public Health Service concerning which persons should receive prophylaxis and what specific prophylactic regimens should be used. The resulting guidelines are detailed below.*

Background

Since the early 1980's, management of PCP has become increasingly successful, and several effective chemotherapeutic regimens are available.[1] However, such conventional therapy as trimethoprim-sulfamethoxazole or parenteral pentamidine is often complicated by adverse reactions that may require termination of the therapy[2], and the mortality for first episodes of PCP is still 5%-20%. Thus, prevention of PCP is a preferred alternative to treating patients for successive episodes of this disease.

Prophylaxis against PCP is categorized as primary if the goal is to prevent an initial episode for a person who has never had PCP. Prophylaxis is categorized as secondary if the goal is to prevent subsequent episodes for a person who has already had at least one episode of PCP.

Risk of Initial Episode of PCP

Immunologic and clinical parameters can be helpful in determining which HIV-infected persons are at particular risk for having PCP and, therefore, which are most likely to benefit from prophylaxis against PCP. In the Multicenter AIDS Cohort Study (MACS), an ongoing prospective epidemiologic investigation of the transmission and natural history of HIV infection among homosexual men,[3] there was a strong association ($p<0.001$) between the baseline numbers of T-helper lymphocytes (CD4+ cells) and the incidence of PCP (Table I.) Additionally, a Kaplan-Meier estimate for 323 participants whose counts of CD4+ cells were $<200/mm^3$ during the study showed that the proportions who had PCP by 6, 12, and 36 months were 13%, 24%, and 39%, respectively.

Similar results were seen when MACS data were analyzed by fraction of CD4+ cells expressed as a percentage of total lymphocytes rather than by absolute number of such cells. In a multivariate analysis of the prospective MACS data, thrush and persistent fever (temperature of >100°F) were additional independent predictors of the development of PCP among patients with CD4+ counts of $<200/mm^3$ at their most recent evaluation (Panel of experts,* Phair and Munoz).

A retrospective study to investigate the levels of CD4+ at which adult patients develop PCP confirms the MACS data.[4] For the 49 episodes of PCP studied, the CD4+ counts

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* This article was reprinted with permission from the CDC, *Morbidity and Mortality Weekly Report*, June 16, 1989, Vol. 38, No. S-5.

were 1-365/mm³ (median 26/mm³), and the percentage of circulating lymphocytes that were CD4+ positive was 0-25% (median 4%) within 60 days before the episode. [A figure detailing the study is available in the original publication, MMWR, June 16, 1989, Vol. 38, No. S-5.]

Risk of Recurrent PCP

For HIV-infected persons who have had one episode of PCP, there is a high probability that a second episode will occur if no prophylactic measures are taken. Although zidovudine will reduce the frequency of second episodes,[5] some persons who receive zidovudine have been reported to have subsequent episodes. In an ongoing study of HIV-infected patients who have had a recently documented episode of PCP (AIDS Clinical Trial Group Study 002), zidovudine therapy was started using two different dosing regimens.[6] The study has not yet been unblinded so that investigators can determine which patients received which zidovudine regimen. A preliminary analysis was done on the risk of recurrent PCP for 318 patients followed for up to 6 months and for 122 patients followed up to 12 months on zidovudine (Panel of experts, * Fischl). [A figure of this analysis is available in the original publication, MMWR, June 16, 1989, Vol. 38, No. S-5.] . These results indicate a need for PCP prophylaxis in addition to antiretroviral therapy.

Table I. Cumulative incidence* of *Pneumocystis carinii* pneumonia (PCP) according to CD4+ count at baseline among the MACS seroprevalent cohort+

CD4+ count at baseline	N	PCP	Percentage with PCP 6 mo.	12 mo.	36 mo.
≤ 200	77	19	8.4	18.4	33.3
201-350	217	47	0.5	4.0	22.9
351-500	389	39	0.0	1.4	9.0
501-700	483	43	0.0	0.4	8.3
>700	499	20	0.0	0.0	3.8

Kaplan-Meier estimates. Both the Logrank and Wilcoxon test statistics for differences in PCP rates by CD4+ count are statistically significant (p<.001).
+ Participants who have taken prophylactic medication have been excluded.

Source: Alvaro Munoz, Ph.D., and John Phair, M.D., personal communication.

Regimens for Prophylaxis

The two compounds studied most extensively for prophylaxis against PCP have been trimethoprim-sulfamethoxazole, given orally, and pentamidine, given as an aerosol.

Trimethoprim-Sulfamethoxazole

The efficacy of trimethoprim-sulfamethoxazole for prophylaxis against PCP has been clearly demonstrated among pediatric cancer patients.[7-8] The only reported randomized controlled trial of this drug combination for HIV-infected persons was a primary-prophylaxis study of 60 adult AIDS patients with Kaposi sarcoma, and compared the effect of no treatment with that of a regimen of 160 mg trimethoprim plus 800 mg sulfamethoxazole twice daily plus 5 mg leucovorin calcium once daily.[9] Compared with untreated patients, those who received prophylaxis had fewer episodes of PCP and lived longer. Adverse reactions were common (50%) and included nausea, vomiting, pruritus, and rash, although these reactions also occurred commonly among patients who were not receiving trimethoprim-sulfamethoxazole. Only five patients (17%) had to discontinue prophylaxis. There are no results from controlled trials currently available for analysis to indicate whether trimethoprim-sulfamethoxazole would be effective or tolerated in other populations of HIV-infected patients.

Aerosol Pentamidine

Clinical studies of aerosol pentamidine for prophylaxis against PCP have been completed by two pharmaceutical sponsors. These studies have used different nebulizing devices and different dosing regimens.

In July 1987, a randomized, nonblinded dose-comparison study of aerosol pentamidine was begun in 14 community treatment centers.[10] The trial was open to adult patients who had already had PCP (secondary prophylaxis) as well as patients with Kaposi sarcoma and other symptomatic HIV-associated conditions who had never had PCP (primary prophylaxis). Patients were randomly assigned to three dose schedules: 30 mg every 2 weeks, 150 mg every 2 weeks, or 300 mg every 4 weeks of pentamidine delivered by the Respirgard II jet nebulizer (Marquest, Englewood, CO).

An interim analysis 1 year after the start of randomization (mean follow-up of 10 months) showed that 76 PCP episodes (13 first episodes and 63 recurrent episodes) had occurred: 33/135 (24%) in the 30-mg group, 25/134 (19%) in the 150-mg group, and 18/139 (13%) in the 300-mg group. For patients receiving secondary prophylaxis, the regimen of 300 mg every 4 weeks was associated with substantially fewer episodes of PCP than the regimen of 30 mg every 2 weeks. There are insufficient data currently available from patients receiving primary prophylaxis to demonstrate statistically significant treatment effects among the regimens.

The most common adverse effects during treatment were cough and, less frequently, wheezing- particularly among smokers and patients with a history of asthma. These effects could be reduced or prevented by pretreatment with inhaled brochodilators. No systemic toxicity of the type associated with parenteral pentamidine (e.g., renal insufficiency, hypoglycemia, or neutropenia) was detected, although other

reports suggest that systemic adverse effects can occur. Patients tolerated the therapy well with supervision, and only two had withdrawn because of side effects at the time the interim analysis was done.

On the basis of these interim results and existing epidemiologic data from natural-history studies, the Food and Drug Administration approved a treatment IND for aerosol pentamidine as both primary and secondary prophylaxis, recommending the 300-mg dose every 4 weeks and recommending delivery via the Respirgard II jet nebulizer. The indication for primary prophylaxis in the treatment IND is a CD4+ count of <200/mm^3. Secondary prophylaxis is indicated for anyone who completes therapy for an episode of PCP.

Other nebulizers have been used in trials of aerosol pentamidine prophylaxis. A double-blinded, placebo-controlled randomized multicenter trial has recently been conducted in Canada which assessed the safety and efficacy of aerosol pentamidine administered by a Fisons ultrasonic nebulizer (five 60-mg loading doses followed by biweekly doses of 60 mg). These findings have been submitted to the FDA. A study using the Fisons nebulizer and three different doses of aerosol pentamidine has also been completed in the United State and is currently being evaluated.

Recommendations

On the basis of the data summarized above and the opinions of individual members of the panel of experts, the Public Health Service recommends that - unless contraindications exist - physicians should initiate prophylaxis against PCP for any HIV-infected adult patient who has already had an episode of PCP, even if the patient has been receiving zidovudine. Unless contraindicated, prophylaxis should also be initiated for HIV-infected patients who have never had an episode of PCP if their CD4+ cell count is <200/mm^3 or if their CD4+ cells are <20% of total lymphocytes. Patients with CD4+ cell counts of <100/mm^3 or CD4+ cells <10% and patients with oral thrush or persistent fever (temperature of >100°F) are particularly high risk for PCP.

Patient Evaluation

For HIV-infected persons, CD4+ lymphocyte percentages or counts should be monitored at least every 6 months. Some experts prefer to obtain a second count within a few months of the first count to assess the rate of decline. Subsequent CD4+ enumerations may be desirable at intervals of <6 months in certain situations such as: a) the presence of fever or thrush, b) a recent rapid decline in CD4+ cell count, c) a CD4+ percentage in the 20-30 range, or d) a CD4+ absolute number in the 200-300/mm^3 range. If a decision to start prophylaxis is to be made on the basis of a low CD4+ cell count or percentage, the CD4+ enumeration should probably be repeated, unless previous determinations indicate the low count or percentage is consistent with an established trend.

Some patients may have discordant CD4+ percentages and absolute counts, i.e., the percentage may be >20% while the CD4+ count may be <200/mm^3, or vice versa. In such cases, it is probably prudent - after reconfirming the CD4+ enumerations - to assume that the patient is at high risk for PCP if either of these two parameters is in the high-risk range.

Clinicians should be aware that in certain unusual circumstances, either the absolute CD4+ count or the CD4+ percentage may not be an accurate reflection of susceptibility to PCP. For example, after splenectomy, HIV-infected patients may be susceptible despite CD4+ counts. Conversely, some laboratory reagents may not detect CD4+ markers on the T-helper cells of all persons,[11] so that such persons may speciously appear to be in the susceptible range. In situations in which this phenomenon is suspected (e.g., when the sum of the number of CD4+ cells and CD8+ cells does not approximately equal the number of CD3+ cells), the lymphocyte sample should be retested with other CD4+ reagents.

Before prophylaxis against PCP is administered, patients must be evaluated to exclude certain active pulmonary disease. If symptoms, signs, or radiologic abnormalities suggest that active disease is present, a thorough evaluation for community-acquired pathogens (e.g., *Pneumococcus*), opportunistic pathogens (e.g., *Pneumocystis*, cytomegalovirus), communicable pathogens (e.g., *Mycobacterium tuberculosis*), tumors, or other processes is indicated. As with other HIV-infected persons, these patients should be given a Mantoux skin test with 5-TU tuberculin, PPD.[12]

Choice of Prophylactic Agent

Scientific studies available to date suggest the following two approaches are effective and safe, although neither has been approved as labelling indications by the Food and Drug Administration.

1. Although it has been studied less extensively among HIV-infected persons than aerosol pentamidine, oral trimethoprim-sulfamethoxazole (160 mg trimethoprim and 800 mg of sulfamethoxazole) can be given twice daily with 5 mg leucovorin once daily. This form of prophylaxis should not be given to patients with a history of type-1 hypersensitivity (angioedema or anaphylaxis) or prior episodes of Stevens-Johnson syndrome associated with sulfonamides or trimethoprim. The efficacy of leucovorin in prevention of toxicity is unknown.

2. Aerosol pentamidine can be given as 300 mg every 4 weeks via the Respirgard II jet nebulizer. The dose should be diluted in 6 ml of sterile water and delivered at 6 liters/minute from a 50-PSI compressed air source until the reservoir is dry. (Further information can be obtained by telephoning the Treatment IND number: 1-800-727-7003.) Because other doses and aerosol delivery systems have not yet been ade-

AIDS IN ARKANSAS 1989
January 1 - August 8, 1989

Total number of cases reported	50
Number of deaths	22

CASES BY SEX

Male	45
Female	5

CASES BY RACE

White	38
Black	11
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	33
Homosexual & IV Drug User	5
IV Drug User	6
Hemophiliac	0
Transfusion	1
Heterosexual (Contacts)	4
NIR#	1

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	1
20 - 29	16
30 - 39	23
40 - 49	6
50 - 59	3
60 or more	1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	16
Kaposi's Sarcoma	2
Pneumocystis Carinii and Kaposi's Sarcoma	0
Other Diseases	32

AIDS IN ARKANSAS
1985 - 1989

Total number of cases reported	223
Number of deaths	135

CASES BY SEX

Male	207
Female	16

CASES BY RACE

White	173
Black	48
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	147
Homosexual & IV Drug User	27
IV Drug User	23
Hemophiliac	1
Transfusion	10
Heterosexual (Contacts)	11
NIR#	4

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	3
20 - 29	74
30 - 39	97
40 - 49	31
50 - 59	9
60 or more	8

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	99
Kaposi's Sarcoma	10
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	108

Source: Arkansas Department of Health.

quately studied and analyzed, no recommendations regarding such systems can be made. For patients who develop cough or wheezing while receiving aerosol pentamidine, pretreatment with a bronchodilator can be tried before the aerosol therapy is given. Patients with asthma or an extensive history or smoking may not tolerate this form of therapy, and it may not be prudent treatment for a patient with a prior life-threatening reaction to parenteral pentamidine.

Since neither aerosol pentamidine nor oral trimethoprim-sulfamethoxazole prophylaxis is known to be safe in association with pregnancy, it is inadvisable to give either agent to HIV-infected pregnant women. Rather, such women should be monitored carefully for symptoms, signs, or laboratory abnormalities suggestive of PCP. Prophylaxis can then be considered for use in the postpartum period. Careful monitoring is also indicated for patients intolerant of aerosol pentamidine and trimethoprim-sulfamethoxazole, or for those unwilling to receive prophylaxis.

Alternative regimens that are of unproven efficacy and safety for humans, but that might be considered for prophylaxis, include dapsone (daily or weekly), dapsone plus trimethoprim (daily or weekly), or dapsone plus pyrimethamine (daily or weekly) and pyrimethamine-sulfadoxine (weekly).

Follow-up of Patients Receiving Prophylaxis

Since none of the regimens has been shown to be completely protective against PCP for HIV-infected persons, patients who receive prophylaxis should be monitored closely for evidence of PCP, as well as other pulmonary infections. If prophylaxis is discontinued, the patient will again be at increased risk for developing PCP.

Prophylaxis failures have been reported in which persons given aerosol pentamidine, especially at low doses, later had PCP in the upper lobes of the lung.[13] In addition, prophylaxis using aerosol pentamidine does not offer protection against extrapulmonary pneumocystosis.[14]

Prophylaxis for Infants and Children

Pneumocystis carinii pneumonia is a common manifestation of pediatric AIDS. Most experts agree that some form of prophylaxis is warranted for HIV-infected pediatric patients who are at high risk for PCP on the basis of criteria that are analogous to those described above for adults. However, there are insufficient data about the efficacy or toxicity of prophylactic regimens for pediatric patients, so that no scientifically validated guidelines can be provided as yet. There are no data concerning the appropriate dose or delivery system of aerosol pentamidine for infants or children. The appropriate dose of trimethoprim-sulfamethoxazole prophylaxis might be estimated from trials involving pediatric cancer patients (e.g., trimethoprim 75 mg/M^2 plus sulfamethoxazole 375 mg/M^2 given orally every 12 hours).[7,8]

Further Information

Several studies are under way to gain additional information about prophylaxis against PCP. Information about these studies can be obtained from the National Institute of Allergy and Infectious Diseases Information Office (1-800-TRIALS-A) or the American Foundation for AIDS Research (212-333-3118).

Editorial Commentary

These guidelines for prophylaxis against PCP indicate a medical benefit from the careful clinical and immunologic monitoring of persons infected with HIV and have several important implications. First, the guidelines are likely to increase the demand for HIV antibody testing by persons who believe they may be at risk for infection. The Public Health Service has estimated that between 945,000 and 1.4 million persons in the United States are infected with HIV.[15] Of these persons, CDC estimates that approximately 120,000 have been informed of their infection status as a result of voluntary antibody testing carried out in public (primarily Federally funded) HIV counseling and testing centers. The number of persons found through other sources of testing to be infected is unknown, but it is likely that many persons who are infected are not aware of their infection. Persons at risk who have not had HIV antibody testing should now consider such testing because they may be candidates for prophylaxis against PCP if they are found to be infected.

Second, the guidelines are likely to increase the demand for medical services by asymptomatic HIV-infected persons. Such persons will need medical evaluation to determine whether they are candidates for prophylaxis against PCP, and - if prophylaxis is given - these persons will need medical follow-up. All persons found to be infected at HIV counseling and testing centers should be referred for further medical evaluation, including a measurement of their CD4+ cells. Facilities offering HIV counseling and testing should develop referral networks of medical-care providers sufficient to evaluate and care for the infected persons they identify. These networks should include services related to family planning and treatment for intravenous drug addiction, sexually transmitted disease, and tuberculosis.

Third, the guidelines are likely to increase the demand for flow-cytometry services to quantify CD4+ cells from HIV-infected persons. Laboratories to which samples are referred for flow cytometry should have prior experience, since methodology can greatly influence the quality of test results. Although there are no true reference standards for evaluating blood cells, quality can be assured by adhering to criteria that address sample collection, preparation, instrument calibration and standardization, flow cytometric analysis, and adequate training of operators.[16] Either absolute CD4+ counts or percentage CD4+ cells can be used in monitoring HIV-infected persons. There appears to be less day-to-day fluctuation in percentage of CD4+ cells compared with absolute number, suggesting that the former measure may be more reliable.[4,17] This finding is not

unexpected since the percentage of CD4+ cells is directly measured by flow cytometry, whereas the absolute number is calculated from the absolute and differential white-blood-cell count and the percentage of CD4+ cells.

Fourth, health-care providers who administer aerosol pentamidine as prophylaxis against PCP should be aware of several occupational safety issues. In particular, they should note the recommendation to exclude active pulmonary disease before starting prophylaxis. A recent investigation of *M. tuberculosis* infections among the staff members of a health clinic in Florida suggested that one source of infection may have related to the use of aerosol pentamidine treatment for two patients who had positive sputum cultures for *M. tuberculosis* during the time they received aerosol pentamidine. One of these two patients coughed profusely both during and after therapy.[18] Providers administering aerosol pentamidine should also review the manufacturer's instructions for the use of the nebulizer system. The Respirgard II nebulizer contains a filter designed to remove most of the pentamidine from exhaled gases. If the nebulizer is improperly used, substantial amounts of pentamidine can be released into the environment, and health-care workers or others in the vicinity may be at risk for the same adverse events as the patients who received the therapy.[19]

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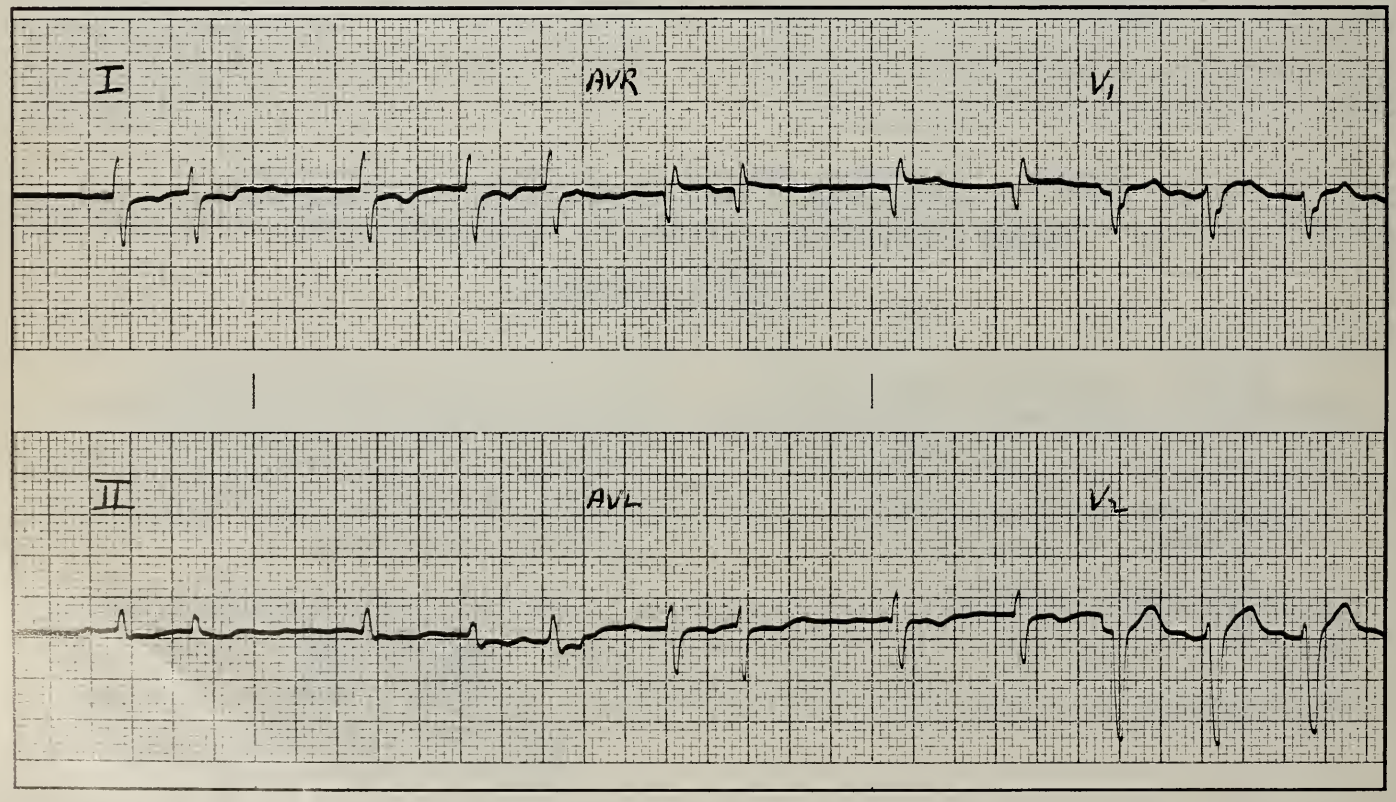
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Little Rock, Arkansas

CLINICAL HISTORY:

M. R. is a 35-year-old woman who presented because of weight loss and palpitations. On physical examination, the vital signs were normal. A goiter was present and a tremor was noted. The reflexes were hyperactive at the knee, ankle and biceps. The heart was irregular in an irregular manner and an S_3 gallop was noted. An ejection type heart murmur was present. What do you think about her electrocardiogram and her presentation?

DISCUSSION:

The electrocardiogram shows atrial fibrillation and nonspecific ST-T changes. Her history and physical examination join to suggest hyperthyroidism which stands as a cause of atrial fibrillation. Further evaluation confirmed hyperthyroidism. With treatment, the atrial fibrillation, gallop sound, and murmur all vanished.



Problems Relative to Special Education Services in Arkansas

E. W. Ashcraft, M.D. and Tom Nosal, L.C.S.W., A.C.S.W.*

Editor's Note: *This is the second article in a three-part series on special education in Arkansas and its implications for the medical community. The first article, "Special Education in Arkansas" appeared in last month's issue of the* Journal. *The final part of the series, "Early Intervention Services for Developmentally Delayed Infants and Toddlers in Arkansas", will appear in the October 1989* Journal.

Introduction

There are innumerable problems relative to special education placement within this State; perhaps the most important of which is that of the cost and availability of resources required by the provisions of Public Law 94-142. In a relatively poor, rural state such as Arkansas, many school districts have a great deal of difficulty recruiting and paying the salaries of regular classroom teachers, much less providing all of the related services that are needed to include speech and language pathologists, physical therapists, and all ancillary related services. Likewise, it is extremely difficult to recruit trained personnel who are necessary to provide these services (especially to the more rural school districts in Arkansas).

Discussion

A major problem in this state exists in the interpretation of the state guidelines for special education placement. There is a broad range of interpretations of the special education guidelines in terms of initial child find and appropriate placement procedures due to the vague language of the special education laws. Likewise, parents are often noninformed of their rights within the public school situation as dictated by Public Law 94-142. The parents are often unaware of how they can assist in the development of an optimal individual education plan. This problem can be compounded by the fact that some parents may be rather apathetic about their child's school placement. While the parents are the best advocates for their children, outside agencies are often necessary to assist parents in optimal placement in the school. Examples of such agencies that help with advocacy, legal support, and appropriate resources for the child are listed in the Table I.

There are countless issues that face the school in the delivery of services for these children. Many chronically ill children evidence no unusual learning problems but may require the medical and physical accommodations in order to participate in school. Under specific guidelines of Public Law 94-142, these children need "related services without needing special education"; yet, by definition, there can be no related services without special education placement. Chronically ill children may need specialized instruction (i.e., vocational/career preparation, adaptive physical education, nutrition, and appliance care) in addition to instruction in the traditional academic areas. These needs are considered by many teachers and administrators to be outside the purview of the public schools. For the most part, professional preparation programs for the handling of medical matters in the classroom are unavailable.

Teachers' biases and attitudes regarding expectations for academic achievement in chronically ill children often results in exaggerated deference to the medical implications of the child's underlying handicap. The teacher, the parent, and the physician may have different and sometimes incompatible goals for a chronically ill chid. Also, the teachers' biases and attitudes toward having a retarded, handicapped, or chronically ill child in the classroom may have a negative impact on all involved.

The development of plans for children with special health needs is all too often limited to services that are available already in the school system rather than the services that the child actually needs. The cost to local education agencies are cited as a deterrent to the provision of the broad range of health services that may be needed for any given child.

A major problem with chronically ill children is the frequent interruption in school attendance (for prolonged hospitalizations, regular weekly treatments, or unpredictable three or four day absences). Current home and hospital school programs are characterized by a great diversity in rules, requirements, and quality.

The need for supportive services in schools complicates educational placement in programs for all chronically ill children. Services may include special diets, physical

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Table I. Advocacy, Legal Support and Resource Agencies in Arkansas

Protection and Advocacy System (Federally mandated)

Advocacy Services, Inc.
3rd Floor, Medical Arts Building
12th and Marshall Streets
Little Rock, AR 72202
(501) 371-2171
(800) 482-1174

General Advocacy

Arkansas Coalition for the Handicapped
519 East 5th Street
Little Rock, AR 72202
(501) 376-3420

Legal Assistance (Eligibility based on income)

Central Arkansas Legal Services
209 West Capitol, Suite 36
Little Rock, AR 72201
(501) 376-3423

Legal Services of Arkansas, Inc.
615 West Markham
Little Rock, AR 72201
(501) 376-8015

Advocacy for Persons with Specific Handicapping Condition

AR Association for Visually Impaired Children & Youth
P. O. Box 34021
Little Rock, AR 72202
(501) 664-3670

AR Epilepsy Society
2311 Biscayne Drive, Suite 110
Little Rock, AR 72207
(501) 225-8000

AR Alliance for the Mentally Ill Help and Hope, Inc.
4313 West Markham, 129 Hendrix Hall
Little Rock, AR 72201
(501) 661-1548

AR Association for Hearing Impaired Children
Lynn C. Coates, President
2214 North Palm Street
Little Rock, AR 72207
(501) 661-1444

Association for Retarded Citizens of AR
6115 West Markham, Room 107
Little Rock, AR 72205
(501) 661-9992

AR Association for Children and Adults with Learning Disabilities
P. O. Box 7316
Little Rock, AR 72217
(501) 555-8777

therapy, special transportation, special physical handling, liaison services, and in-school administration of medication and treatments, such as urethral catheterization. Schools have limited health services for all children, and few educational authorities have developed or implemented specific policies and programmed health centers for children with special needs.

Chronically ill children in the school have a great need for emotional support and opportunities to experience normal peer relationships. Some of the obstacles to meeting these needs include erratic attendance patterns, mild adaptive social behavior, embarrassing side effects of specific diseases, and isolation due to equipment needs or geographic location. Perhaps the most important obstacle is the unavailability of support for parents in coping with the chronic illness.

Finally, mainstreaming in the least restrictive environment may become the most restrictive environment for any given child. First, there is a lack of regular classroom teachers who have any preparation in serving the needs of a learning disabled or handicapped child. Secondly, some administrators fail to understand the nature of the problem and, as a result, are generally unsupportive of teachers. Thirdly, there exists a practice of administratively assigning learning disabilities (along with special education students) to a department of pupil personnel. Classroom teachers do not need more pupil personnel services; rather, they need assistance from experts in instruction and curriculum. They also need help in modifying educational techniques and materials to the exigencies of the child's learning deficits. A child placed in a so-called least restrictive environment, who is unable to achieve, who lacks an understanding teacher, who does not have appropriate learning materials, who is faced with tasks that he cannot manage, whose failure results in negative comments by his classmates, and whose parents reflect frustration toward the child when at home, is in an environment which is restrictive from all sides.

Important legislation is being considered by the State of Arkansas to optimize all special education services within the state. We, as physicians, need to be supportive of any and all legislation which insures that maximal educational experiences are afforded to every child within this state. In order to achieve this, there will need to be funding, adequately trained personnel, adequate provision of services, and a consistent approach to the entire mechanism for placement and treatment for all handicapped children.





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RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

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OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience;* Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
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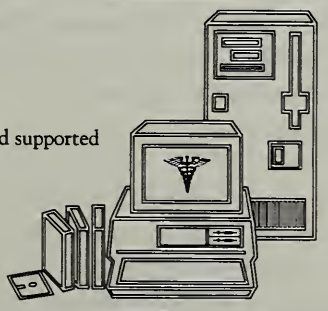
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There are 23 area churches of various denominations. The Mountain Home public schools has the average enrollment of 3,423 students, and the North Arkansas Community College serves about 1,018 students. Mountain Home has hunting, fishing, water sports, theaters, a golf and racquet club, tennis and aerobic centers.

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Population of Malvern is 10,163; population of the area physician would serve is approximately 28,124.

Opportunities exist for an orthopaedic surgeon and an obstetrician-gynecologist. Hot Spring County Memorial Hospital, a 77-bed county hospital, is offering a start-up contract for a practitioner. Office space is available in the hospital-owned clinic adjacent to the hospital.

There are fourteen practicing physicians in Malvern, including family or general practice, internal medicine, and general surgery.

Industry in the community includes Reynolds Metal Company, Acme Brick, Universal Die Casting, Arkansas Power and Light, Amoco Products, International Paper, Featherlite Manufacturing Company, Williamette Industries and Natural Gas Pipeline Company.

Malvern has three elementary schools, one junior high school and one high school, with an average enrollment of 2,969; a country club with a 9-hole golf course, numerous civic clubs, 40 churches representing all faiths commonly found in this section of the country, and a county medical society.

Four lakes are within a 30 mile radius of Malvern.

CONTACT: Mr. Michael E. Henze, Administrator, Hot Spring County Memorial Hospital, 1001 Schneider Drive, Malvern, AR 72104, 501-337-4911, extension 114 or 115

For more information about these and other positions available; or if you would like to place your community with the Physician Placement Service, contact Ms. Laura Harrison, Arkansas Medical Society, Post Office Box 5776, Little Rock, Arkansas; (501) 224-8967 or outside Little Rock, 1 (800) 542-1058.

The Diagnosis and Management of Male Infertility

Amer Z. Al-Juburi, M.D. and Pat D. O'Donnell, M.D.*

Introduction

There are many aspects of infertility that can be evaluated and managed in every doctor's office or clinic. The primary care physician is often the first medical contact that is made by the patient. An informed and concerned relationship with the patient in that instance is very important. The most important concept for the physician in the initial management of infertility is the need for the physician to consider infertility as a "couple problem" rather than a physical abnormality in one partner. It cannot be overemphasized that the couple must proceed as a unit through the various tests and procedures used to diagnose fertility problems. The emotional aspects of infertility is also important and has been well described previously.[1]

Discussion

In order for a couple to be considered infertile, they should have had unprotected intercourse for 12 months or longer without occurrence of conception[2] (in older couples, a shorter interval may be significant and cause them to seek treatment). During this time, adequate coital exposure should have occurred. A frequency of two to three times per week without use of lubricants or douches (these can be spermicidal) is considered adequate.[3,4] It is further thought that the woman should remain recumbent for 10 to 15 minutes following coitus. No other special positions or regimens are known to improve fertility and may cause disruption of spontaneous sexuality which is discouraged.

An estimated 25% of married couples now seek fertility counseling and treatment (15% are childless marriages, 10% are unable to have a second child). It was found that 40% of infertility cases have a male factor, 40% have a female factor, 10% to 15% have combined factors and 5% to 10% have no abnormality. In the clinical management of infertility, a plan of investigation should be outlined to the couple with supporting explanations. An explanation of the causes of infertility provides an ideal introduction to the need for future assessment. The schedule can be flexible for individual couples, but in no case should it take more than three to six months. It is essential that both partners are present during initial evaluation and both should be interviewed together. Separate physical examinations should follow, during which each partner should be questioned again on matters which he or she may prefer to conceal from the other. If the couple is not ready for a complete work up, basal body temperature (BBT) charting should be explained and a semen analysis should be planned to be performed prior to an appropriately timed return visit. Table I summarized the steps in infertility investigation.

Table I. Infertility Investigation

- Initial visit - history and physical for both partners
- Semen analysis
- Documentation of ovulation
  - BBT charts for two months
  - Luteal phase progesterone
- Post-coital test
- Hysterosalpingogram
- Laparoscopy

Although both partners must be evaluated and treated simultaneously, the objective of the following description is the evaluation and management of infertility in men. Men often resist evaluation and treatment of infertility. They equate a fertility problem with male inadequacy and may confuse infertility with impotence. Men often need to be reassured that even though they may be infertile, their sexual functioning capacity is normal. Table II and III demonstrate the relevant points in male history and the key areas of the male physical examination.

Semen analysis, although an imperfect measurement, is the most reliable and cost-effective assessment of male infertility. It should be the first test performed and should be carried out as soon as possible. The specimen should be collected by masturbation at the same location where the

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Table II. Relevant Points in History

Previous fertility (does not guarantee present fertility)		
Sexual development (growth, shaving, etc.)		
Sexual dysfunction (difficulties with erection, ejaculation, libido)		
General health (recent or chronic illness, medications)		
Social habits	-	alcohol, tobacco, other drugs
Urogenital	-	infection, V.D. mumps, other
	-	surgery - cryptorchidism, torsion, hernia repair, hydroceles trauma

analysis of the ejaculate is being performed. This allows control over the timing of the collection, the examination, the temperature variations, the certainty of collecting the whole specimen, and the cleanliness of the container. Care in collection of the specimen is required for reliability of the results of the test. The patient is requested to abstain from sexual activity for three days before giving the ejaculate specimen. A masturbated specimen should be collected in a widemouthed container such as urine culture bottle that is clean and biologically inert. Semen specimens obtained from the patients at different times occasionally give different results, especially in number of sperm per milliliter. Abnormal specimens should be repeated at least two more times at three week intervals so that temporary fluctuations are not misinterpreted. Three semen specimens are necessary to confirm a diagnosis of abnormal semen. Because of the biological variation in sperm counts, variation in measurement method must be minimized in order for the outcome to be reliable. A specialized infertility lab is the best facility to use in these circumstances. Table IV illustrates the normal values of the semen analysis. A persistently abnormal semen analysis requires further evaluation to determine the cause. The evaluation is usually best performed by someone with a special interest in male infertility. Other semen evaluation tests may be done as indicated; mucous-sperm interaction tests, the Zone Free Hamster Egg Penetration Test.

Although a complete discussion of the pathophysiology is beyond the scope of this article, initial tests may include blood count, liver function tests, urinalysis and syphilis screen. Cultures of urine, semen, and prostatic secretions

Table III. Key Areas in Physical Exam

General
- Appropriate height/weight
- Blood pressure
- Neurological status
- Endocrine disease (gynecomastia, striae)

Sexual Characteristics
- Hair distribution
- Testicles - size, consistency
- Epididymis/vas - presence and condition on palpation
- Hydroceles/varicoceles - size, location
- Penis - size, condition of skin, urethral location (hypospadias)
- Prostate - size, shape, consistency, secretions (any WBCs?)

are sometimes helpful to rule out suspected infections, including chlamydia. Hormonal evaluation includes thyroid, gonadotropins, prolactin and testosterone. In practice, oligospermia most likely will be found to be secondary to disease rather than as a presenting complaint.[4,5] In the absence of obvious stigmata, an idiopathic etiology is most likely. Prior to proceeding to therapy of diagnostic surgery, it is helpful to obtain follicle-stimulating hormone, testosterone, and prolactin levels to rule out silent pituitary or testicular abnormalities. Testicular biopsy, scrotal exploration, and vasography may be employed to delineate testicular etiology from congenital or acquired ductal obstruction. Abnormal karyotypes are occasionally encountered, but routine screening is not indicated. Table V outlines the causes of male infertility and its percentage according to our present knowledge and data.

Table IV. Basic Normal Semen Values

Ejaculate volume	1-5 ml of semen
Density	>20X10^6 sperm per ml of semen
Motility	>50% of sperm in semen should be motile
Morphology	>60% normal sperm forms in semen

Table V. Etiology of Male Infertility

Varicoceles	47%
Idiopathic infertility	23%
Hormonal causes	13%
Azoospermia	7%
Infections	5%
Miscellaneous causes (semen volume, immunologic, drug-related)	5%

Approximately 5% to 10% of couples with infertility have no abnormality. This probably represents the limits of current technology in assessing gamete competence, embryogenesis, functional sperm capacity, and early pregnancy. Many couples with unexplained infertility are subfertile, as 30% of them will conceive within a longer time span and others will exhibit fertility with other partners. Possible causes for the conditions are controversial and can sometimes involve costly investigation or risky therapy. If a man has a varicocele which appears to be associated with semen defects, it should probably be repaired if it remains the most important variable in the couple's infertility problems and if they understand that its repair may not result in a pregnancy in the partner. Clomiphene has been applied to men with altered semen quality and a normal Follicle-Stimulating Hormone (FSH).[6,7] Semen quality and FSH should be checked every 6-8 weeks. If there is a hormonal response by >50% FSH baseline and/or improvement of the semen quality, the patient may continue the medication up to 15 months. The dose that we usually recommend is 300

mg/week given on a pulsating phenomenon of 100 mg every other day. Tamoxifen has also been used but as with Clomid, results are not encouraging in improving semen quality and resulting in pregnancy.[8,9] HCG injection may be used twice weekly in a dose of 4000 IU per injection for a 12 week course. Steroids in different kinds of regimen have been used in suspension and/or documentation of anti-sperm antibodies. Non-specific medications have been used frequently in an attempt to improve semen quality in the male patient with normal hormone levels and the absence of a varicocele.

New developments in treating sperm defects include: In-Vitro Sperm Manipulation Techniques,[11,12] Sperm Washing,[9,10] Swim Down and Swim Up,[9] and other techniques such as the use of "percoll"[13] gradients or the freezing concentrations of several samples.

Conclusion

Infertility is a common problem that adversely affects couples in varying degrees. Both partners must be evaluated simultaneously. Regardless of which partner has the fertility problem, both must participate and support one another during the diagnostic and treatment phases. Management requires an understanding of psychological factors as well as reproductive physiology.

When it is the man who is found to have a problem that prevents conception, a careful workup may establish the cause, and in many cases, provide the basis for a successful treatment approach. Current research and development in infertility is exciting and is likely to result in many more new developments in the near future that will benefit couples with fertility problems.

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Clinical Experience with Ciprofloxacin

John Richard Hann, M.D., Brian Frederick Sudderth, M.D., Robert V. Baker, M.D., and Roy Erving Harrison, M.D.*

In a multicenter study of 30 patients treated with ciprofloxacin (mean daily dosage, 1000 mg per day; mean duration of treatment, 10.6 days) for a variety of infections, 14 were microbiologically proven. Of these, bacteriologic cure and/or improvement resulted in 92.3% of cases. For all 30 infections clinical cure and/or improvement resulted in 88.9% of cases. A total of ten infections were classified as chronic. Overall there were 5/30 (16%) adverse reactions (ADRs), however, only two were definitely related to ciprofloxacin therapy. For three ADRs the relationship to therapy was uncertain. Therapy with ciprofloxacin was discontinued in one (3.3%) patient because of adverse effects. Four patients elected to continue ciprofloxacin therapy despite mild side effects.

Introduction

Ciprofloxacin (CIPRO®) is a newly approved (1987) antimicrobial which demonstrated high activity in vitro against gram-negative and gram-positive aerobic pathogens.[1,2] It has excellent in vitro activity against *Enterobacteriaceae* species, *Pseudomonas aeruginosa*, *Haemophilus* and *Neisseria* species.[3] Orally administered, ciprofloxacin exhibits therapeutically achievable Minimal Inhibitory Concentrations (MICs) against methicillin-resistant *Staphylococcus aureus* and is the most potent oral antimicrobial available for use against this pathogen.[4] Therefore, ciprofloxacin has been regarded as an excellent oral alternative to injectable antibiotics.

Most of the literature reports double-blind, controlled comparative trials intended for submission to the FDA for marketing approval. However, these studies contain extremely restrictive inclusion and exclusion criteria and may or may not be related to how the product would perform in the day to day practice of medicine. Thus, an evaluation of the efficacy and safety of ciprofloxacin in day to day medical practice was performed. In the following, data from an open clinical multicenter study performed in the state of Arkansas is reported.

Patients and Methods

Guidelines for patients admitted into the study were established by a standardized protocol. Data was collected on brief, two-page Clinical Evaluation Forms (CEFs) completed by the investigators. Subsequently, the CEFs were retrieved and analyzed by Oxford Health Care, Inc. in Clifton, New Jersey. Each physician investigator categorized all patients' infections as either lower respiratory tract, soft tissue, skin and skin structure, or other. Four investigators from Arkansas entered 30 patients into the study. Only those patients who receive ciprofloxacin alone as antimicrobial therapy were evaluated.

Several criteria determined patient selection. Inclusions: male and female inpatients or outpatients over 18 years of age who exhibited clinical evidence of lower respiratory tract infection, skin and skin structure infection, or soft tissue infection. Exclusions: females who were pregnant, nursing, or not practicing contraception; patients with known or suspected allergy to quinolone antibiotics or with known moderately to severely impaired renal function; those displaying clinical evidence of hepatic disease or requiring other concomitant antimicrobial therapy; and patients with known clinically impaired immunological function.

Physicians were asked to record adverse reactions, their duration and intensity, and the action taken in regard to medication adjustment or outcome. Any serious or unexpected reaction was to be reported within 72 hours to Miles, Inc. The investigators were to use their judgement regarding patient response to therapy and to adjust antimicrobial medication if response was determined inadequate. Patients were allowed to receive any other medication deemed necessary by the physician. The package insert acted as the guideline for prescribing information.

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Bacteriology

Specimens were collected, when available, from sites of suspected infection prior to the administration of ciprofloxacin. Physicians were also asked to obtain a culture at the end of ciprofloxacin therapy if culturable material was available. Sensitivity analysis was performed using ciprofloxacin disks provided by Miles, Inc. For patients with respiratory tract infections, sputum was processed for gram stain and culture whenever possible. However, many lower respiratory tract infections and closed wound infections precluded collection of a culture specimen.

Table I. Final Clinical Outcome Classified by Location of Infection*

	% of total (number of patients)			
	Cure	Improvement	Failure	Cure and Improvement
Lower respiratory tract	42.9(3)	28.6(2)	28.6(2)	71.5
Soft tissue	87.5(7)	0(0)	12.5(1)	87.5
Skin/skin structure	66.7(4)	33.3(2)	0(0)	100
Urinary tract	0(0)	100(1)	0(0)	100
Other	80(4)	20(1)	0(0)	100
Total	66.7	22.2	11.1	88.9

*Data unavailable for three patients.

Results

A biostatistician at Oxford Health Care, Inc., supervised data processing. The statistics generated were descriptive in nature, tabulated exactly from the CEF. Complete as well as incomplete CEFs were included in the results, regardless of whether the physician followed every protocol parameter. All patients were included in the analysis of clinical efficacy, however, only those patients who had a positive culture with an identified organism were included in the evaluation of bacteriologic efficacy.

No patient who receive any type of anti-infective medication concomitantly with ciprofloxacin was evaluable for either safety or efficacy. All 30 patients, with the exclusion of those who receive a concomitant antimicrobial, were included in the analysis of tolerance to the drug and of adverse effects of treatment. The data indicated that no patient received a concomitant antimicrobial in this study. Skewed data were eliminated when necessary.

A total of 30 patients (15 men and 12 women reported), aged 29 to 82 years (mean age 56.8 years) received 1000 mg of ciprofloxacin per day (mean dosage 1000 mg per day) for 4 to 21 days (mean duration, 10.6 days).

The spectrum of infections treated comprises a variety that would be expected in a multicenter trial with four participating physicians from across the state. For the total patient population the majority of infections were classified as soft tissue (29.6%), followed by lower respiratory tract (25.9%), skin and skin structure (22.2%), urinary tract (3.7%) and other (18.5%). It should be noted that the majority of patients treated, 88.5%, were outpatients; hospitalized patients accounted for only 11.5% treated. No patients were continuing ciprofloxacin therapy at the time of the evaluation.

Patients were evaluated for both clinical and bacteriologic efficacy. All patients who receive one dose of ciprofloxacin were considered for the evaluation of the clinical efficacy of therapy, regardless of whether a culture was obtainable. Physicians were asked to rate the final clinical outcome of the infection by indicating cure, improvement or failure. Final clinical outcome of therapy with ciprofloxacin for each diagnostic category is summarized in Table I. Clinical cure was achieved in 66.7%, improvement in 22.2% of cases. Overall clinical cure plus improvement equaled 88.9% of treated infections. Only three patients (11.1%) had outcomes considered clinical failures by the treating physician.

Patients who had an initial culture that identified a pathogen were included in the analysis of bacteriologic efficacy. Cultures were obtained in 19 patients initially. Of these, the bacteria cultured and the outcome of therapy was specified in 14 cases. Negative cultures and cultures indicating normal flora were not evaluable. Within these parameters, the infection was microbiologically proven for 14 of 30 patients. Of the evaluable patients, bacteriologic cure equaled 84.6%, while improvement comprised 7.7%. Cure plus improvement was 92.3%. Failure was reported in only 7.7% of cases. For one case the data on outcome was unavailable. Interestingly, bacteriologic outcome was equal to or better than clinical outcome.

In the 14 positive cultures, 15 organisms were identified. These 15 organisms were distributed across the diagnostic categories in the following manner: the majority of infections were classified as skin and skin structure (46.7%), followed by soft tissue (33.3%) and other (20%). There were no positive cultures in either the lower respiratory or urinary tract. Though urinary tract infection was not a category on the CEF, it was statistically separated for discussion and analysis. The seven reported pathogens and their bacteriologic outcome are summarized in Table II.

For all 30 patients, ten (35.7%) infections were considered chronic. Both the final clinical and bacteriologic outcomes were indicated for the chronic infections. For three patients information was available as to the final outcome. Two patients were cured (66.6%) and one patient improved (33.3%). Additionally, information was available as to bacteriologic outcome for three patients. Again, two patients were cured (66.6%) and one patient improved (33.3%). No failures were reported in either category.

Adverse Reactions

All 30 patients treated with ciprofloxacin were included in the evaluation of tolerance and averse effects related to

Table II. Seven Pathogens Identified in 14 Evaluable Cultures and Bacteriologic Outcome

	OUTCOME		
Type of Organism	Cure	Imp	Fail
Staphylococcus aureus	7	0	1
Proteus species	1	1	0
Pseudomonas aeruginosa	0	1	0
Streptococcus pneumoniae	1	0	0
Staphylococcus epidermidis	1	0	0
Enterobacter cloacae	1	0	0
Staphylococcus hyicus	0	1	0

therapy. Of the 30 patients, 25 reported no side effects (83.3%). Five reports of ADRs were observed; two cases of mild vaginitis, one case of moderate candida overgrowth, and one case of continued fever. No headaches or rashes were reported. Only two of the ADRs were considered definitely drug-related, the candida overgrowth and the vaginitis. Ciprofloxacin therapy was maintained in four cases, and discontinued in the case of continued fever. Only in one patient (3.3%) was therapy discontinued because of adverse reactions.

Abnormal laboratory findings were reported for six patients; however, in three cases information was unavailable as to the specific test or its finding. Furthermore, the remaining three abnormal laboratory reports were not related to administration of ciprofloxacin. For example, a report of right sided pneumonia was listed as an abnormal laboratory result. No findings were indicative of adverse effects stemming from the use of ciprofloxacin. No reports of crystalluria were found.

Discussion

A relatively new class of antimicrobials, the fluoroquinolones, has emerged as a powerful new resource for physicians to treat a broad spectrum of infections. Ciprofloxacin is a potent member of this drug classification.

Analysis of this multicenter study indicates that there is a good correspondence between the in vitro activity of ciprofloxacin and the clinical efficacy of treatment with ciprofloxacin. Clinical cure was observed in 66.7% of all infections. Cure plus improvement equaled 88.9% of all cases. The small sample size in the lower respiratory tract category, seven infections, is the most likely reason for the 28.6% failure rate. This failure rate was incorporated into the overall data, yet overall clinical failure was still only 11.1%.

Bacteriologic efficacy (cure plus improvement) equaled 92.3%, while clinical efficacy was 88.9%. For chronic infections the overall bacteriologic efficacy was identical to clinical efficacy; 100% were rated as cured and/or improved. Though the number of chronic infections was small, the cure rates were still quite high.

The safety of ciprofloxacin was assessed for all patients. Overall, therapy with ciprofloxacin was extremely well tolerated. Adverse experiences were infrequent and generally mild. Treatment with ciprofloxacin had to be discontinued for only one patient because of adverse experiences.

Furthermore, physicians reported 23 classifications of medications that were administered concomitantly with ciprofloxacin. Hypoglycemics, diuretics, analgesics and bronchodilators headed the list. Still, adverse reactions were minimal. No patients were reported to have had an allergic reaction to ciprofloxacin, nor were any incidents of theophylline toxicity reported.

Conclusion

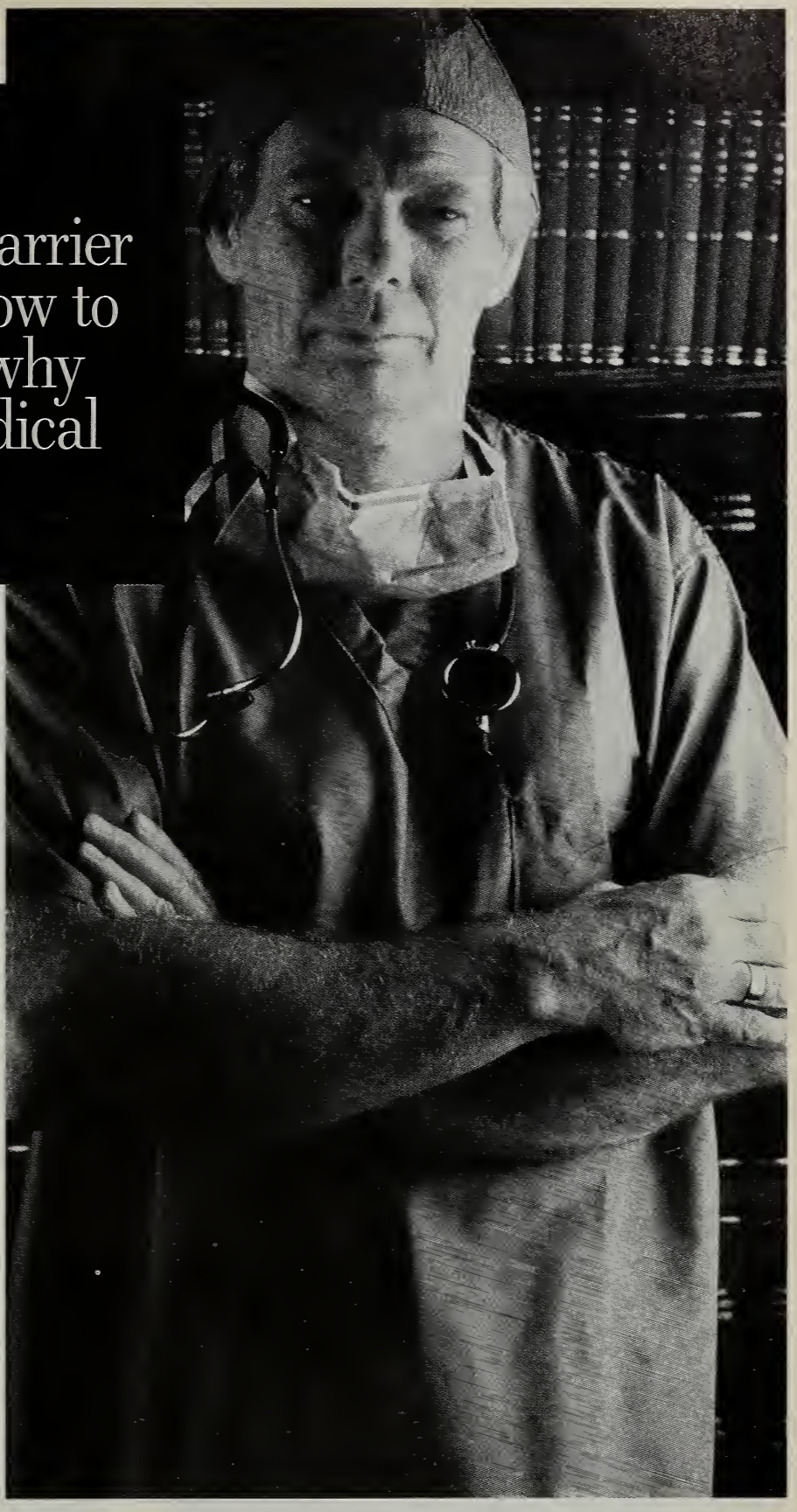
The isolation of etiologic bacteria is difficult, especially in infections of the lower respiratory tract and in closed wound infections. Clinical results reported here include cases with and without obtained culture and sensitivity results. Bacteriologic efficacy was determined by culture and sensitivity. The main purpose of the study was to gather a large amount of safety and efficacy data on ciprofloxacin, after its FDA approval, as used in a day to day clinical setting in order to confirm the results in smaller, more restrictive trials used for FDA approval of the product.

The present clinical experience has shown that a dosage of 500-1500 mg/day (1000 mg/day in this study) of ciprofloxacin therapy is effective in a broad spectrum of infections including *E. coli*, *Staphylococcus aureus*, *Proteus* species, *Streptococcus* species, including *S. pneumoniae*, *Pseudomonas* species and *Staphylococcus epidermidis*. In addition to an overall clinical efficacy (cure plus improvement) of 88.9%, the bacteriologic efficacy in 14 patients was 92.3%. As stated earlier, the small sample size in lower respiratory tract infections was the most likely reason for the skewed cure rates.

Furthermore, the safety of ciprofloxacin was excellent. Adverse reactions were generally mild, gastrointestinal in nature and infrequent. In conclusion, it appears that ciprofloxacin offers ease of administration as well as high efficacy and safety in the treatment of a wide variety of infections that might well have previously required parenteral therapy and/or hospitalization.

References

1. Sanders CC, Sanders Jr WE, Goering RV. Overview of preclinical studies with ciprofloxacin. Am J Med 1987; 82:Suppl 4A:2-11.
2. Barry AL, Jones RN. In vitro activity of ciprofloxacin against gram-positive cocci. Am J Med 1987; 82:Suppl 4A:27-32.
3. Lyon MD, Smith KR, Saag MS, Cobbs CG. Brief report: in vitro activity of ciprofloxacin against Neisseria gonorrhoeae. Am J Med 1987; 82:Suppl 4A:40-1.
4. Data on file. Miles Inc. Pharmaceutical Division.



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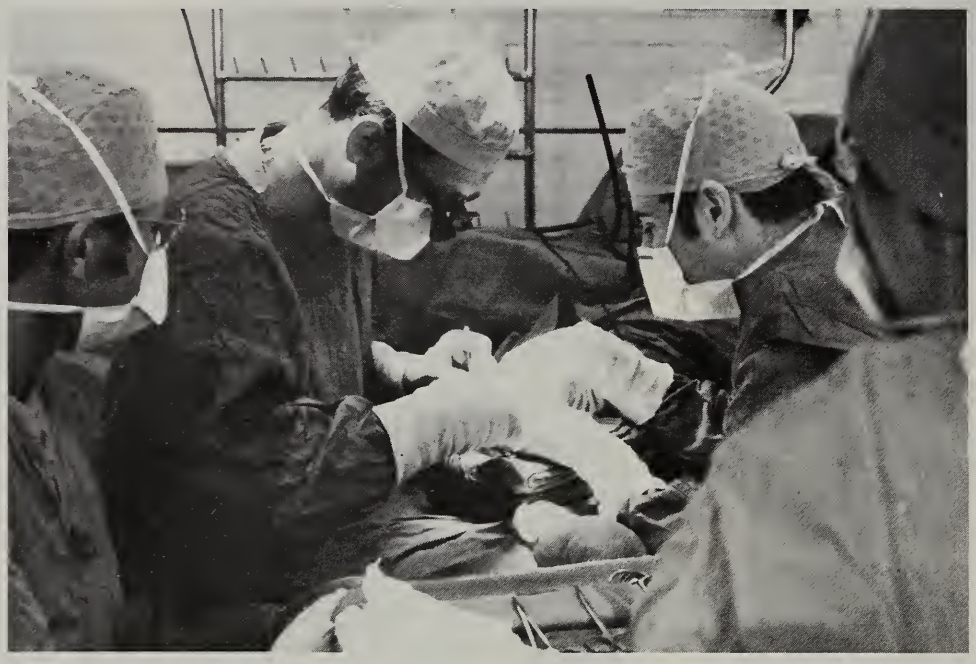
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Alan Cazort, M.D.

Joe W. Matthews, M.D. and Vida Gordon, M.D.

Alan Cazort, M.D. was truly the "Father of Allergy" in Arkansas and was one of the pioneer clinical allergists in the United States. He died at the age of 86 years on August 14, 1986.

He was born in Clarksville, Arkansas and was one of eleven children. His mother died when he was ten years old. Having been raised in a rural environment he developed early a love for the outdoors and botany. He walked or rode a horse several miles to school. Education was very important to his family and to him, too. He graduated from Hendrix College, Arkansas in 1922 and from the Arkansas College of Medicine in 1928.

Formal allergy teaching programs and indeed allergists in general were uncommon in the 1930's. Since he was afflicted with severe asthma himself he had an insider's perspective of both the disease and the treatment available at that time. In order to improve his knowledge of allergy he took clinical apprenticeships in the offices of experts in the field. These included Drs. Billy Duke, Frances Rackermann, Bret Ratner, and Robert Cooke among others. He returned to Arkansas to begin practice limited to allergy and volunteered his services to the Arkansas College of Medicine, starting his teaching there in 1935. He was the first and only allergist in Arkansas for several years.

Dr. Cazort had a very investigative approach to allergy and was disenchanted by the commercial extracts then available. His knowledge of botany and chemistry induced him to collect antigens and prepare his own extracts for testing and treatment. He pioneered in establishing the effective doses of Adrenalin for asthmatics and its effect on the blood pressure and vital capacity. His paper on Penicillin allergy published in the *Journal of the Arkansas Medical Society* was one of the earliest ones published. The same could be said for his articles on house dust allergy.

Most of the allergists practicing in Arkansas including the authors were encouraged by Dr. Cazort's example to enter his new and sometimes controversial specialty. In recognition of this fact, the Arkansas allergists named their local society The Alan Cazort Allergy Society of Arkansas.

In his personal life, Dr. Cazort was a plain spoken, kindhearted individual who shared generously both his experience and financial means to assist others in improving themselves. He was a member and past president of the Pulaski County Medical Society, an executive board member of the American Academy of Allergists, and a charter member of the Southwest Allergy Forum. He was married for fifty-five years to the late Mary Carpenter Cazort whom he met at Hendrix College. He is survived by four daughters, all of whom have been successful in their respective fields, and eight grandchildren. Dr. Cazort was loved and respected by his family, neighbors, professional colleagues, and patients. He was one of those rare individuals who placed service to others above self-interest.



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THINGS TO COME

SEPTEMBER 18-21

41st AAFP Annual Scientific Assembly. Sponsored and presented by AAFP. Los Angeles Convention Center. Category I credit available. For complete information contact: Beth Paulsen, AAFP at 1 (800) 274-2237.

SEPTEMBER 27-29

Women and Self Esteem: Exploring the Forces that Enhance and Diminish the Self. Sponsored by the Menninger Clinic. Ramada Inn Tower Plaza, Topeka, KS. Nineteen Category I credit hours; 18.45 hours for social workers; and 19 contact hours for nurses. Fees: $235 per person. For further information, contact: Jayne Roberts, Conference Coordinator, The Menninger Clinic, 1 (800) 288-7377.

OCTOBER 5-7

AMA Conference on the Prevention of Family Violence and Victimization. Sponsored and presented by the AMA. Chicago Hilton & Towers, Chicago, IL. Hour for hour Category I credit available (14 hours total). Fees: $225; $100, students. For further information, call 1-(800) 621-8335.

OCTOBER 5-7

Biomedical Image Processing with Microcomputers. Sponsored and presented by Washington University School of Medicine Continuing Medical Education. Marriott's Pavilion Hotel, St. Louis, Missouri. Hour for hour Category I credit available. For further information, contact: Loretta Giacoletto, Washington University School of Medicine, Office of Continuing Medical Education, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862.

OCTOBER 6-8

Trends in Pediatrics. Presented by George D. Comerici, M.D.; Ronald C. Hansen, M.D.; Andrew Margileth, M.D.; Paul G. Dyment, M.D.; and Milton I. Arnold, M.D., Course Monitor. Sponsored by the American Academy of Pediatrics. Marriott's Mountain Shadows, Scottsdale, Arizona. Sixteen Category I credit hours. Fees: AAP Resident and Candidate Fellows, and Allied Health Professionals, $220; AAP Fellow, $300; Nonmembers, $365. Discount airfares available. For further information contact: CME Registration Department of Education, American Academy of Pediatrics, Post Office Box 927, Elk Grove Village, IL 60009-0927; 1 (800) 433-9016.

OCTOBER 18-27

Allergy Abroad - Italy. Sponsored and presented by Washington University School of Medicine Continuing Medical Education. Padua, Florence, Rome, Italy. Twenty Category I credit hours. Fee: $495. For further information, contact: Loretta Giacoletto, Washington University School of Medicine, Office of Continuing Medical Education, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862.

OCTOBER 19-22

33rd ASIM Annual Meeting. Costs, Quality & Controls: Seeking the Right Balance. Sponsored and presented by ASIM. Includes ASIM business meetings, congressional visitation program for delegates, etc., organized for October 18. ASIM Board will meet both days. Category I credit available. For further information, contact: Barbara Lauter, ASIM, 1101 Vermont Avenue, NW, Suite 500, Washington, D.C. 20005-3457; (202) 289-1700.

OCTOBER 20-21

Cancer Conference IV. Presented by the faculty from M.D. Anderson Medical Center, Houston, TX. Sponsored by Greene County Medical Society (Missouri) and the American Cancer Society. Big Cedar Lodge, Table Rock, MO. Nine Category I credit hours. For further information, call Greene County Medical Society (Missouri) (417) 887-1017.

NOVEMBER 6-9

Primary Care Update: 74th Scientific Assembly of Interstate Postgraduate Medical Association. Sponsored by Interstate Postgraduate Medical Association. Town & Country Hotel, San Diego, CA. Twenty-four Category I and AAFP credit hours. Registration fee: $200, advance; $225, on-site, $35, residents and interns; $50, allied health professionals. Further information, Interstate Post Graduate Medical Education, Post Office Box 5474, Madison, WI 53705; (608) 257-1401.

NOVEMBER 19-21

Fourth National Forum on AIDS and Hepatitis B. Sponsored by the American Medical Association. Washington, D.C. For further information, contact the National Foundation of Infectious Diseases, 4733 Bethesda Avenue, Suite 750, Bethesda, MD 20814; (301) 656-0003.

NOVEMBER 26 - DECEMBER 1

75th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Presented and sponsored by RSNA. McCormick Place, Chicago, IL. For further information, contact Carolyn Mills, RSNA at (312) 558-1770.

FEBRUARY 1990

31st Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. Sponsored and presented by the Johns Hopkins University School of Medicine. February - April 1990: Home Study Course A is provided for personal reading and microscopic study in own laboratory in preparation for Course B. April 23 - May 4: In-Residence Course B is an extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore, MD. One hundred and fifty-two Category I credit hours. Registration must be complete before January 1, 1990. For further information, contact, John K. Frost, M.D., or Ms. Betty Ann Remley, 111 Pathology Building, Johns Hopkins Hospital, Baltimore, MD 21205; (301) 955-8594.

KEEPING UP

Cholesterol: Current Concepts for Physicians

Self-Study Course for Physicians. Sponsored by the National Heart, Lung and Blood Institute. A national cholesterol education program is available through the Arkansas Medical Society office in which a physician studies at home. Two Category I credit hours. Further information: David Wroten, Arkansas Medical Society, Post Office Box 5776, Little Rock, AR 72215; (501) 224-8967.

Failure to Thrive

September 13, 12:30 p.m. Presented by James Cheshier, M.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Nutrition and Aging V: Impact of Nutrition on Aging

September 13-14, 8:00 a.m. - 4:30 p.m. Presented by David A. Lipschitz, M.D., Ph.D. and Ronni Chernoff, Ph.D., R.D. Sponsored by UAMS College of Medicine. Excelsior Hotel, Little Rock. Eleven Category I credit hours. Fee: $150; V.A. employees, $60.

Family Therapy

September 15, 12:30 p.m. Presented by Fred Hagemeier, Ed.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Laser Photocoagulation of Vascular and Pigmented Malformation

September 15-16, 7:30 a.m. - 5:00 p.m. Presented by Milton Waner, M.D. Sponsored by UAMS College of Medicine. UAMS Education Building, Room G108 A & B. Twelve Category I credit hours. Fee: $875.

Pediatric Allergies

September 19, 12:30 p.m. Presented by J. T. Howell, M.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Management Strategies in Congestive Heart Failure

September 21, 2:00 p.m. - 4:45 p.m. Presented by George L. Ackerman, M.D. Sponsored by UAMS College of Medicine. Holiday Inn West, Little Rock. Two and one-half Category I credit hours.

Revised Arkansas Medical/Legal Examination Seminar

September 22, 9:00 a.m. - 4:15 p.m. Presented by J. Ryland Mundie, M.D. Sponsored by UAMS College of Medicine. Baptist Medical Center Conference Room. Category I credit available.

AR Academy of Ophthalmology Annual Meeting

September 22 & 23, 7:30 a.m. Presented by Robert Reinecke, M.D., Philadelphia; and Barry Leader, M.D., New Orleans. Lake Hamilton Resort, Hot Springs. Eight Category I credit hours. Fee: $50.00.

Medical/Surgical Therapies for Acute Myocardial Infarction

September 30, 8:00 a.m. - 2:15 p.m. Presented by L. Scott Cook, M.D., Ph.D. and Joe K. Bissett, M.D. Sponsored by UAMS College of Medicine. Capitol Hotel, Quapaw Room, Little Rock. Five Category I credit hours. Fee: $25.

Doppler Update

September 30, October 1, 11:00 a.m. - 3:35 p.m.; 8:00 a.m. - 11:25 a.m. Presented by Christopher B. Merritt, M.D., New Orleans, LA; Leo F. Drolshgen, M.D.; David L. Harshfield, M.D.; Robert W. Barnes, M.D.; Charles M. Glaiser, M.D.; Richard E. Leithiser, Jr., M.D.; M. Lee Nix, R.N., R.V.T.; and Joanne J. Seibert, M.D. Sponsored by Arkansas Chapter of the American College of Radiology and the American College of Radiology. Sturgis Auditorium, Arkansas Children's Hospital. Six Category I credit hours. Registration fees: $100. For further information, contact Peggy Buice (501) 663-2244.

Esophageal Reflux & Dyspepsia

October 5, 12:00 noon. Presented by Charles Paris, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Second Annual Fall Surgical Symposium

October 6 - 7, times to be announced. Presented by J. Ralph Broadwater, M.D. Sponsored by UAMS College of Medicine. Gaston's White River Resort, Lakeview, Arkansas. Category I credit and registration fees to be announced.

ATLS Provider Course

October 7 - 8, times to be announced. Presented by Robert W. Barnes, M.D. and Charles D. Mabry, M.D. Sponsored by UAMS College of Medicine. UAMS Education Building, Little Rock. Seventeen Category I credit hours. Fee: $475.

HIV Testing and Counseling

October 12, 12:30 p.m. Presented by Jim Acklin, M.D. and Russell Williams, MSW. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Polycythemia & Anemia

October 17, 12:00 noon. Presented by Robert Arrington, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Effect of Drugs on Renal Function with Emphasis on NSAI

October 18, 12:00 noon. Presented by Andrew Whelton, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Avoiding Problems with the PRO

October 21, 7:30 - 10:00 a.m. Presented by Donald Baker, M.D. Sponsored by UAMS AHEC Northwest. Washington Regional Medical Center, Baker Conference Center, 1125 N. College, Fayetteville. Two Category I credit hours. Fee: $10, includes breakfast.

Primary Care Update

October 26 & 27, times to be announced. Presented and sponsored by Baptist Medical Center Medical Education Department. Baptist Medical Center, J.A., Conference Center. Further information: Baptist Medical Center, Medical Education at (501) 227-2672.

Infectious Disease Update

November 6-11. Presented by Richard F. Jacobs, M.D., Terry Yamauchi, M.D., A. Wesley Burks, M.D. Sponsored by Arkansas Children's Hospital. Camino Real Hotel, Ixtapa, Mexico. Registration fee: $250. Airfare: $150. Twelve hours Category I credit. Further information, Blanche Moore, Continuing Education Director, Arkansas Children's Hospital, 800 Marshall, Little Rock, AR 72202; (501) 370-1481.

Reality Therapy & Families

November 9, 12:30 p.m. Presented by Bruce Allen, L.C.S.W. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

AIDS in Arkansas

November 11, 7:30 a.m. - 10:00 a.m. Presented by Linda Markland, M.D. Sponsored by UAMS AHEC - Northwest. Washington Regional Medical Center, Baker Conference Center, Fayetteville. Two Category I credit hours. Registration fee: $10, includes breakfast.

Pediatrics in Family Practice

November 17, 9:00 a.m. - 4:30 p.m. Presented by Robert Glenn, M.D., and Arkansas Children's Hospital Staff. Sponsored by Arkansas Children's Hospital. Arkansas Children's Hospital, Little Rock. Six Category I credit hours. Registration fee: $80. For information, contact Blanche Moore, Arkansas Children's Hospital, 800 Marshall, Little Rock, AR 72202; (501) 370-1481.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

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Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Building Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, Sturgis Building, Room 121
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Second Floor Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, Sturgis Building, Rooms S120-121
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

Cancer Conference, first Wednesday, 12:00 noon, CARTI Auditorium. A meal is provided.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell Room. A meal is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. A meal is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Arkla Room. Refreshments are provided.
General Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. A meal is provided.
Pediatric Conference, first Tuesday, 12:30 p.m., LaHarpe de Paul Room. A meal is provided.
Peripheral Vascular Disease Conference, fourth Tuesday, 6:00 p.m., Arkla Room. A meal is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, fourth Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS Education Building, Room G137, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:30 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours

Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Fundamental Sciences Conference, first Tuesday, 6:00 p.m., UAMS Chancellor's Area, Conference Room B-2
Surgery Grand Rounds, one Saturday per month, 8:00 a.m., UAMS Education Building, Room G/141A, 1.5 credit hours
Surgery Morbidity and Mortality Conference, Wednesdays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Resident Case Conference, Mondays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Review Conference, Mondays, 6:00 p.m., UAMS Education Building, Room G/141A
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Conference (Pediatric), once monthly, 5:00 p.m., Arkansas Children's Hospital, Sturgis Building, Clinic 2
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Tuesdays, 5:00 p.m., UAMS Education Building, Room G/131A&B

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center

Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

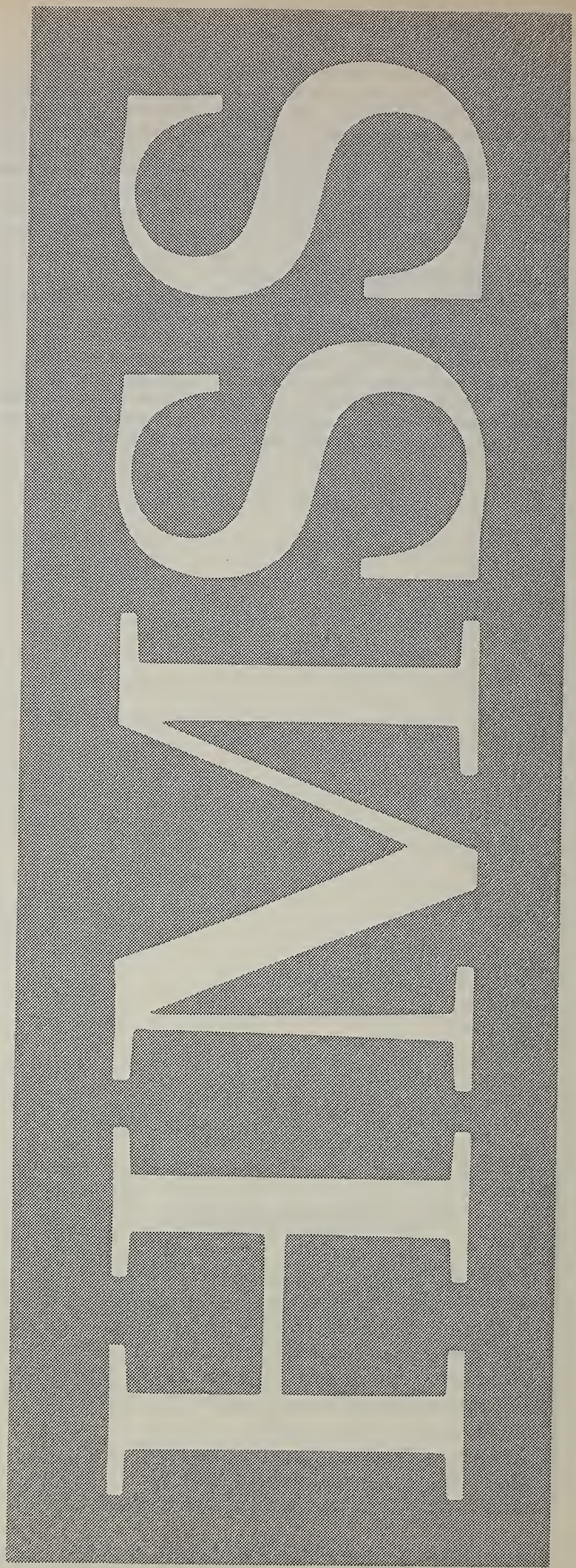
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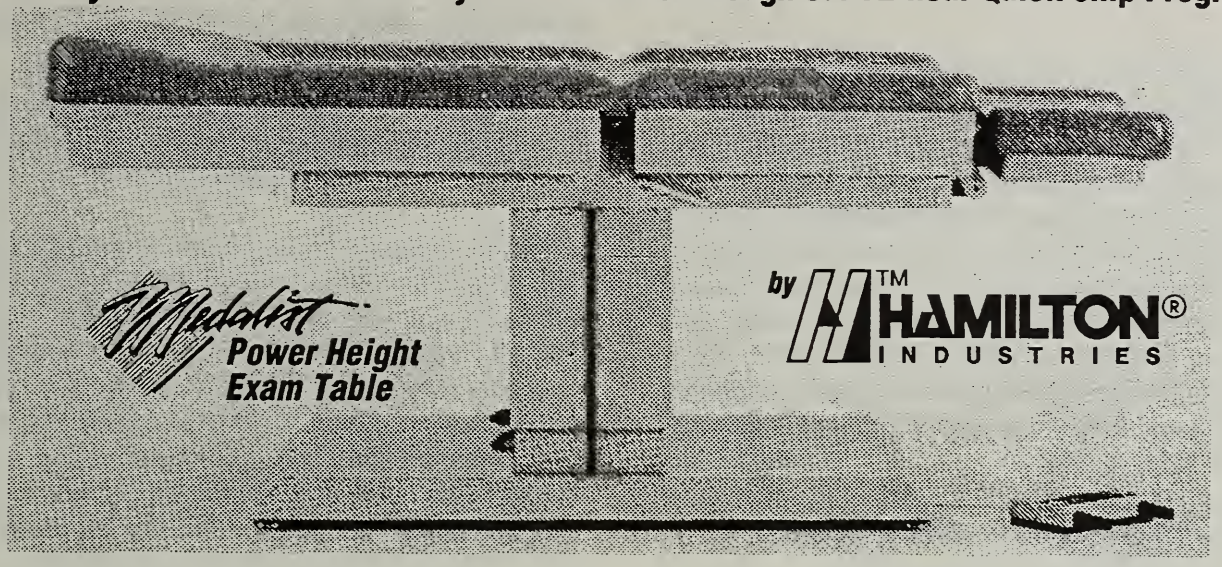
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Practice Management Workshops

The American Medical Association Department of Practice Management is offering two workshops for physicians deciding what to do after residency.

"Starting Your Own Practice" is a two-day program which will provide practical information and techniques for building a profitable practice. "Joining a Partnership or Group" is a four-hour workshop explaining the procedures for joining a partnership or group, two areas of practice which are currently attracting the largest number of physicians starting practice.

Both are offered periodically throughout the year in different locations across the country, as well as on a regular basis in Chicago.

For more information, contact the Department of Practice Management, 535 North Dearborn Street, Chicago, IL 60610; (312) 645-4958.

Quality Intervention Under PRO

Effective April 1, 1989, all of the nation's 54 PROs were to have implemented the new provisions in the Health Care Financing Administration's Third PRO Scope of Work. The Quality Intervention Plan (QIP) is a new provision which has caused particular concern to physicians. Moreover, it has become evident that not all PROs have done a successful job of communicating the essence of the QIP to physicians. Therefore, the following information is being provided on the QIP so that you may be better able to respond to physician concerns.

The provisions relating to the Quality Intervention Plan are one of the more significant changes in the Third Scope of Work. The QIP is a prescribed plan by which each PRO is required to perform a quality review and implement interventions when quality concerns are identified. Under the QIP, once a quality concern is identified and confirmed, it will be assigned a weight by a PRO physician based upon the degree of harm or potential for harm to the patient, i.e., according to the three level severity index. Each severity level has an assigned weight: a weight of 25 for a level III problem, a weight of 5 for a level II problem, and a weight of 1 for a level I problem.

The three levels are defined as follows:

Level III:	Medical mismanagement with significant adverse effects on the patient.
Level II:	Medical mismanagement with the potential for significant adverse effects on the patient.
Level I:	Medical mismanagement without the potential for significant adverse effects on the patient.

Each quarter, the PRO will profile the total weights accumulated for reviews completed in that quarter for each physician or provider. The total weight will determine the type of corrective action to be implemented.

When the quarterly profile shows that a particular physician or provider has a total weighted score of 3 or more, the PRO must initiate corrective action. The type of corrective action to be implemented depends on the assigned weight and trigger level. The six types of interventions and trigger levels in the QIP are:

Trigger Levels	Interventions
3	Notification
10	Educational efforts
15	Intensified review
20	Other interventions
25	Consideration of coordination with licensing and certification bodies
25	Consideration of initiation of sanction proceedings

Each PRO is required to use the HCFA QIP and implement the intervention based upon the above triggers as well as all interventions for lesser trigger levels (e.g., a score of 19 would require notification, educational efforts, and intensified review.)

PRO quality problem profiling will be performed each quarter to determine whether the weighted scores of three or more per quarter, or five per six-month bi-quarter, are reached. This method of review is termed a "rolling" quarter system (i.e., one quarter is removed and a successive quarter is added on). For example, in July, the PRO will profile the April-June quarter, and the January-June bi-quarter; in October, the contractor will profile the July - September quarter and the April-September bi-quarter.

The AMA has questioned HCFA's decision to limit the severity levels to just three categories and to the potential for inflexibility of the point system, and its potential for being perceived as a more arbitrary mechanism. While present indications are that HCFA intends to move forward with these provisions as written, they have made it clear that, by contract, the PRO is prohibited from automatically implementing the most severe interventions (i.e. coordination with licensing and certification bodies,

and consideration of sanction); rather, the PRO must exercise flexibility in determining what intervention is appropriate to the particular case.

Enrollees Sought for Accutane Follow-up

Boston University's School of Public Health is seeking participants for a follow-up survey of women of childbearing potential who take Accutane®(isotretinoin/Roche), a drug used to treat the most severe form of cystic acne, severe recalcitrant cystic acne.

The third-party survey, now under way at the university's Slone Epidemiology Unit, is an integral part of the Pregnancy Prevention Program for Women on Accutane. This program was developed last year by Hoffmann-La Roche, Inc., in cooperation with the Food and Drug Administration (FDA) to reemphasize long-standing warnings that due to the risk of severe birth defects, Accutane must not be used by women who are pregnant or who may become pregnant while undergoing treatment.

The study seeks information from patients on a number of factors, including history of acne and acne treatment, the patient's understanding of how Accutane is to be used and of the hazards of becoming pregnant while taking the drug, methods of contraception while undergoing Accutane therapy, and, in cases where pregnancy does occur, the reason why and the outcome.

All participants receive $10. Women can enroll in the survey through their prescribing physicians or through a form included in each of the product packages. The survey is fairly simple and requires very little time. Some of the women will be asked to fill out a brief questionnaire six months after they complete treatment. Others will participate in a few telephone interviews during and after treatment.

Single Donor Platelet Therapy Monograph Available

"Single Donor Platelets in Transfusion Therapy," a monograph on platelet transfusion therapy, is now available from the Component Therapy Information Bureau, an educational service of Baxter Healthcare Corporation, Fenwal Division.

Author of the monograph is Lilian M. Reich, M.D., Associate Blood Bank Director, Memorial Sloan-Kettering Cancer Center, New York, and Associate Professor of Clinical Medicine, Cornell Medical School.

"Single Donor Platelets in Transfusion Therapy" includes information on indications for platelet therapy and a comparison of multiple and single donor platelets. Alloimmunization, transfusion-associated diseases and graft versus host disease are discussed, as are standards for measuring the efficacy of platelet transfusions and data on the cost, availability, harvesting and storage of single donor platelets.

A free copy of "Single Donor Platelets in Transfusion Therapy," can be obtained by writing the Component Therapy Information Bureau at Post Office Box 620, Deerfield, IL 60015, or calling (312) 940-6400.

AIDS Information Available

The National AIDS Information Clearinghouse (NAIC), a department of the Centers for Disease Control, has free publications, posters, fact sheets and point-of-purchase displays available to educate young people about AIDS. The NAIC has targeted this information for young people aged 10 to 20 and their parents. For a complete list of the educational materials available, contact NAIC at 1 (800) 458-5231. Specialists are also available at that number to answer questions, make referrals, and suggest other publications pertaining to HIV and AIDS.

Recognition and Management of Pesticide Poisoning

The United States Environmental Protection Agency (EPA) has published the fourth edition of *Recognition and Management of Pesticide Poisonings* by Donald P. Morgan of the University of Iowa School of Medicine.

The new edition lists 1,750 active ingredients and brand names (50% more pesticides than covered in the third edition) and updates all treatment procedures. It provides current information on the health hazards of pesticides and consensus recommendations for management and poisoning.

Copies of the publication are available, free of charge, through the Arkansas Agricultural Pesticide Association (AAPA). Contact Ples Spradley, University of Arkansas Cooperative Extension Service, Post Office Box 391, Little Rock, AR 72203; (501) 373-2640, for your copy.

Environment of Medicine Available

The new edition of *The Environment of Medicine* (EOM), from the AMA's Council on Long Range Planning and Development, is available.

The new edition elaborates on the macro-trends affecting medicine, such as the evolving health care economy, the growing supply of physicians, the changing demographic profile of the U. S. population, and public- and private-sector initiatives affecting the practice of medicine.

The new EOM takes a look at several major issues affecting health care: reimbursement of physicians, quality of care, professional liability, shortage of nurses, mandated health care plans, long-term care, and AIDS.

The booklet is $20 for AMA members and $50 for nonmembers. Send prepaid orders to: AMA Book and Pamphlet Fulfillment, OP 223/9, P. O. Box 10946, Chicago, IL 60610-0946. Call (800) 621-8335 with VISA or MasterCard orders.

AMS NEWSMAKERS

Sam L. Shultz, M.D. is the newest member of the Editorial Board for the *Journal of the Arkansas Medical Society*. Dr. Shultz replaced Dr. Robert Glenn whose term of office expired in April. Dr. Shultz received his undergraduate degree from Baylor University and his medical degree in 1966 from the University of Texas Medical Branch in Galveston in 1970. He later received a Master of Public Health Degree from San Diego State University in 1985.



Dr. Shultz is currently a senior staff member of the Arkansas Children's Hospital and has practiced in Arkansas since 1977. He is board certified by the American Board of Pediatrics and is a Diplomate of that same board as well as a Fellow of the American Academy of Pediatrics. Dr. Shultz has written several articles which appeared in the *Journal of the Arkansas Medical Society*. His most recent work, "Recurrent Abdominal Pain in Children," was published in the *Journal of the American Medical Association*.

George W. Warren, M.D., a Smackover family physician and long-time Arkansas Medical Society member and alternate delegate to the AMA, was elected as Vice President to the American Academy of Family Physicians.

Robert Hunter, M.D., was honored at a reception in Magnolia where he is retiring from practice as a radiologist. The reception for Dr. Hunter was held at the Magnolia Hospital where he has been a staff member since 1971.

The National Governor's Association announced recently that **Dr. Joycelyn Elders,** a pediatrician and Arkansas Department of Health Director, was selected to receive a Distinguished Service from the group. This is the thirteenth year the association has given the awards.

Robert W. Barnes, M.D., a Little Rock surgeon and chairman of the Department of Surgery at the University of Arkansas for Medical Sciences, is the new president-elect of the International Society for Cardiovascular Surgeons.

The Arkansas Foundation for Medical Care has elected **Morton C. Wilson, M.D.** as its new chairman. Dr. Wilson is a urologist in Fort Smith and an AMS Councilor for the Tenth District.

Marlon J. Doucet, M.D., a family practitioner in Pine Bluff, was recently elected director of medical services for the Jefferson Comprehensive Care Center.

Dr. Ruth Ellis Lesh, an AMS Emeritus member from Fayetteville, recently gave a gift of $15,000 for a College of Medicine annual scholarship for a senior female medical student. Dr. Lesh gave the gift in memory of her father, the late Dr. Edward Ellis.

The Arkansas Academy of Family Physicians has announced the election of its new officers. They are: **Sam Brown**, Texarkana, President; **Joe Stallings**, Jonesboro, President-elect; **Michael Moody**, Salem, Vice President; **Richard Gardial**, Hot Springs, Treasurer; **Charles Rodgers**, Little Rock, Alternate Delegate; and **Bruce Schratz**, North Little Rock, Delegate. **Michael Justiss**, Pine Bluff; **Dennis Davidson**, Batesville; **Sam McGuire**, Forrest City; **William Dedman**, Camden; and **Michael Young** were all elected to the Board of Directors.

Dr. James Weber, current Arkansas Medical Society president, was selected as the Arkansas Family Physician of the Year. His name will be given to the American Academy of Family Physicians for the national award. In other activities, **Nicholas Riegler** of Little Rock was given a plaque of appreciation from the pharmaceutical industry for his efforts and support.

Support PAC and the State Legislative Fund. Call the Society office at (501) 224-8967 for details.

New Members

ASHLEY COUNTY

Birriel-Salcedo, Tomas, General Surgery, Crossett. Born March 22, 1954, Madrid, Spain. Pre-medical education, University of Puerto Rico, 1974. Medical education, Tulane University School of Medicine, M.D., 1978. Internship/residency, Tripler Army Medical Center, Hawaii. Military experience, 11 years, U. S. Army. Practice experience, 2 years, Stillwell, OK; 3 years, Fort Leavenworth, KS. Teaching appointments, Clinical instructor, 1 year, Academy of Health Sciences, San Antonio. Member, AMSUS.

CHICOT COUNTY

Kuiper, Gregory J., Family Practice, Dermott. Born January 4, 1959, Orange City, IA. Pre-medical education, Dordt College, B.A., 1981. Medical education, University of Iowa College of Medicine, Iowa City, 1985. Residency, Siouxland Medical Education Foundation, Sioux City, IA. Board certified, family practice. Member, AAFP.

JEFFERSON COUNTY

Jacks, Dennis W., Urology, Pine Bluff. Born July 10, 1952, Pine Bluff. Pre-medical education, University of Central Arkansas, B.S., 1974. Medical education, University of Arkansas for Medical Sciences, 1980. Internship/residency, UAMS. Military experience, U. S. Army, 1975-76, 1985-89. Board certified, Urology. Member, American Urology Association; Fellow, American College of Surgeons.

McGee, Mary K., Internal Medicine/Nephrology, Pine Bluff. Born October 5, 1956, Laredo, TX. Pre-medical education, Texas A & M University, B.S., 1978. Medical education, University of Texas Medical Branch, Galveston, 1984. Internship/Residency, Louisiana State University Medical Center, UAMS. Fellowship, LSU Medical Center; UAMS. Board eligible. Member, AMA.

Nichols, William E., Pediatrics, Pine Bluff. Born April 21, 1959, St. Louis, MO. Pre-medical education, University of Arkansas, B.S., 1981. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/Residency, UAMS. Fellowship, University of Florida. Board certified. Member, American Academy of Pediatrics.

LONOKE COUNTY

Garrett, James E., General Practice, England. Born October 22, 1955, Kirksville, MO. Pre-medical education, Northeast Missouri State University, Kirksville, B.S., 1978. Medical education, Kirksville College of Osteopathic Medicine, 1983. Internship, Normandy Hospital, St. Louis. Practice experience, 5 years, St. Louis. Member, American Osteopathic Association.

PULASKI COUNTY

Adametz, James R., Neurological Surgery, Little Rock. Born April 25, 1956, Little Rock. Pre-medical education, Harding University, Searcy, B.A., 1978. Medical education, University of Arkansas for Medical Sciences, 1982. Internship/residency, University of Arkansas for Medical Sciences.

Bates, Ramona L., Plastic/Hand Surgery, Little Rock. Born July 29, 1957, Ft. Leonard Wood, MO. Pre-medical education, University of Arkansas, Fayetteville, B.A., 1979. Medical education, University of Arkansas for Medical Sciences, 1982. Internship/residencies, Earl K. Long Hospital, Baton Rouge, LA; Ohio Valley Medical Center, Wheeling, WV; Mercy Hospital, Pittsburgh, PA; and Boston University Hospital, Boston, MA. Practice experience, 6 months, Calico Rock, AR.

Beadle, Beverly A., Neurology, Little Rock. Born August 9, 1952, Little Rock. Pre-medical education, Ouachita Baptist University, Arkadelphia and University of Arkansas, Little Rock, B.S., 1973. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, University of Arkansas for Medical Sciences. Board eligible.

Mabrey, William T., Ophthalmology, Little Rock. Pre-medical education, University of Arkansas, Fayetteville, B.A., 1979. Medical education, University of Arkansas for Medical Sciences, 1983. Internship/residency, Presbyterian/St. Lukes, Denver, CO; UAMS; Oregon Lions Sight/Hearing Institute, Portland, OR. Board eligible.

Murphy, Joseph S., Radiology, Little Rock. Born December 4, 1959, Hot Springs. Pre-medical education, St. Petersburg Junior College, St. Petersburg, FL and University of Arkansas, Fayetteville, B.A., 1980. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, University of Arkansas for Medical Sciences. Practice experience, Memorial Hospital, North Little Rock, 1 year; Radiology Consultants, Little Rock, 1 year; Baptist Medical Center, Little Rock, 1 year. Board certified, Radiology.

Murphy, Tena E., Cardiology, Little Rock. Born December 25, 1953, Little Rock. Pre-medical education, Randolph-Macon Woman's College, Lynchburg, VA, B.A., 1975. Medical education, University of Arkansas for Medical Sciences, 1983. Internship/residency, UAMS. Board certified, Internal Medicine.

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education, Southwestern State University, Weatherford, OK, B.S., 1968. Medical education, Oral Roberts University, Tulsa, 1983. Internship/residency, University of Arkansas for Medical Sciences.

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Fossey, Carol, Family Practice and Emergency Medicine, Fayetteville. Born August 25, 1951, Paunee, OK. Pre-medical education, University of Oklahoma, B.A., 1973. Medical education, University of Oklahoma, Oklahoma City, 1979. Internship, University of Oklahoma, Oklahoma City. Residency, University of Arkansas, Fayetteville (AHEC-Northwest). Practice experience, Fayetteville, 5 years. Teaching appointments, University of Arkansas, AHEC. Board certified, Family Practice, Emergency Medicine. Member, AAFP, ACEP.

RESIDENT SECTION

Benerjee, Bhaskar, Internal Medicine. Born April 11, 1959, India. Medical school, University of London, England, B.S., 1983. Internship/residency, University of Connecticut School of Medicine, Farmington, Connecticut.

Green, Michael D. Born December 20, 1961, Springdale, AR. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1984. Medical education, UAMS, 1989. Residency, UAMS.

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Rish, James A., Internal Medicine. Born December 23, 1961, Pontotoc, MS. Pre-medical education, University of Mississippi, Oxford, MS, B.A. 1983. Medical education, University of Mississippi, Jackson, 1989. Internship/residency, UAMS.

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RESOLUTION

Paul L. Rogers, M.D.

Whereas, God in His infinite mercy has seen fit to call from our midst, Dr. Paul L. Rogers, and

Whereas, Dr. Rogers has faithfully served his patients, in the community at large throughout his entire medical career, and

Whereas, Dr. Rogers, during his years of practice has reflected the highest ideals of his profession, and

Whereas, in his devotion to family, church and friends, he exemplified the best in man, and

Whereas, the Sebastian County Medical Society mourns his loss, be it therefore

RESOLVED, by the Sebastian County Medical Society, in its regular meeting on May 9, 1989, hereby adopts these Resolutions and directs that a copy be spread on the minutes of the Society and that a copy be furnished the family and that a copy be published in the *Journal of the Arkansas Medical Society*.

Gene Girkin, M.D., President

William R. Cothern, M.D.

Whereas, the members of the Ashley County Medical Society are truly saddened by the recent death of an esteemed colleague, William R. Cothern, M.D., and

Whereas, Dr. Cothern was a member of this society for over forty-one years, and was highly respected in our community, and

Whereas, his concern for his patients and for his country was known by the many hours he contributed to their health needs and by his military service in World War II, be it therefore

RESOLVED, that this resolution be adopted as a token of our appreciation for Dr. Cothern's life and service; and

RESOLVED, that a copy be sent to Dr. Cothern's family as an expression of our heart felt sympathy; and

RESOLVED, that a copy be made available to the *Journal of the Arkansas Medical Society* for publication.

Ashley County Medical Society
Dr. Don L. Toon, President
Dr. Benjamin J. Walsh, Secretary

Memorials honoring Arkansas Medical Society members and their spouses can be made to the Medical Education Foundation for Arkansas (MEFFA), Post Office Box 5776, Little Rock, AR 72215. Call the Society for information.

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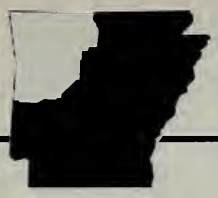


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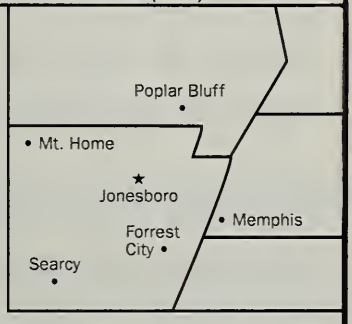
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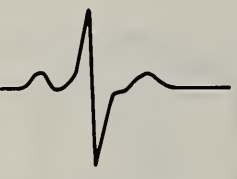
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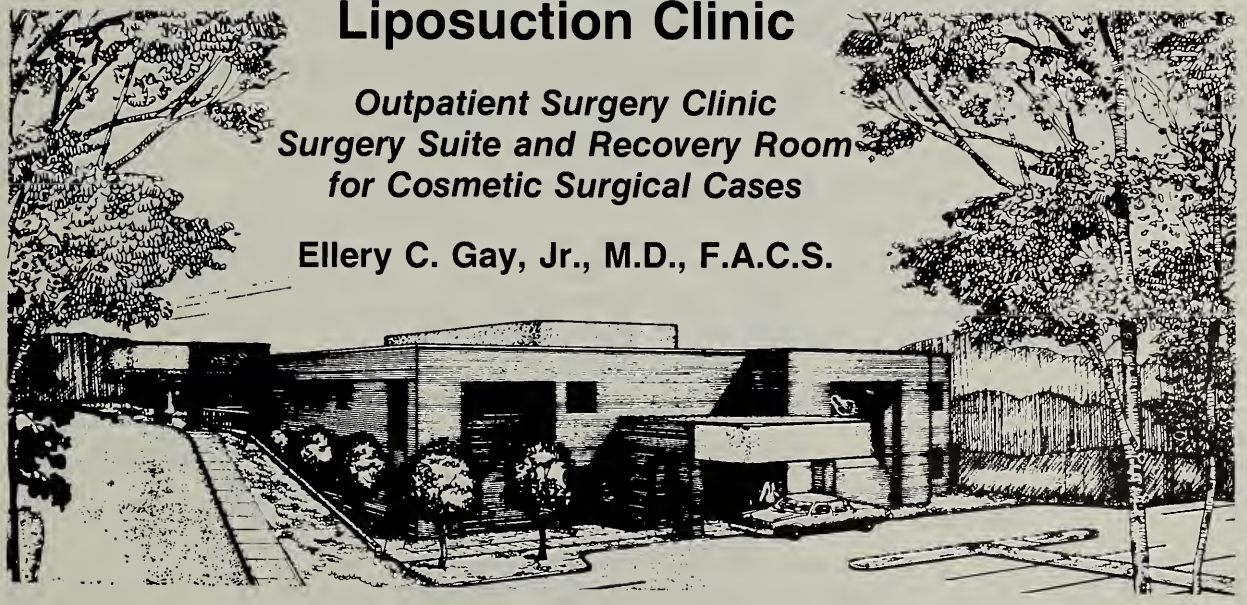
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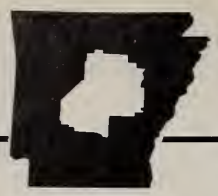
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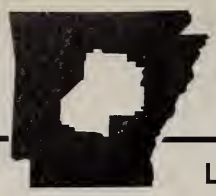
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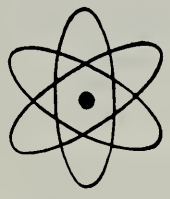
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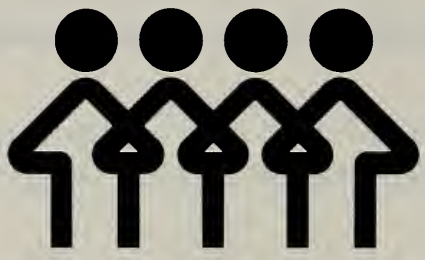
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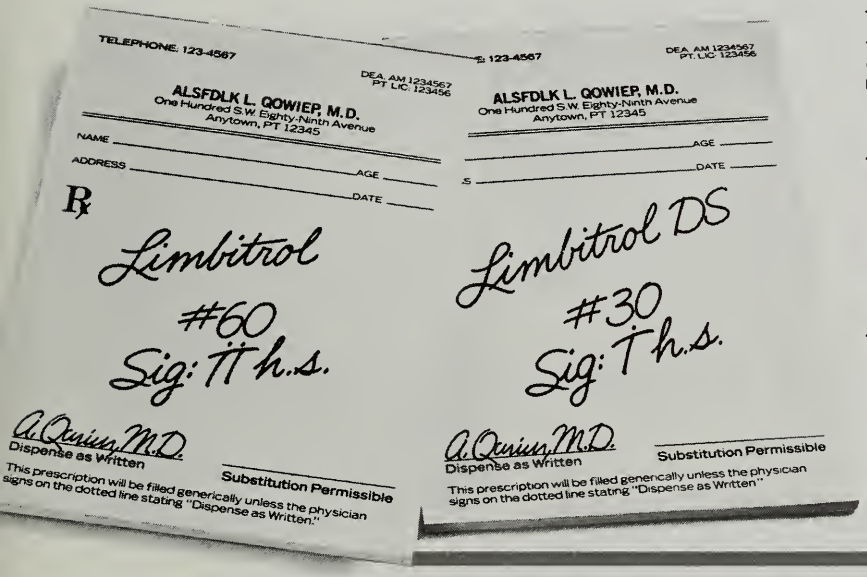
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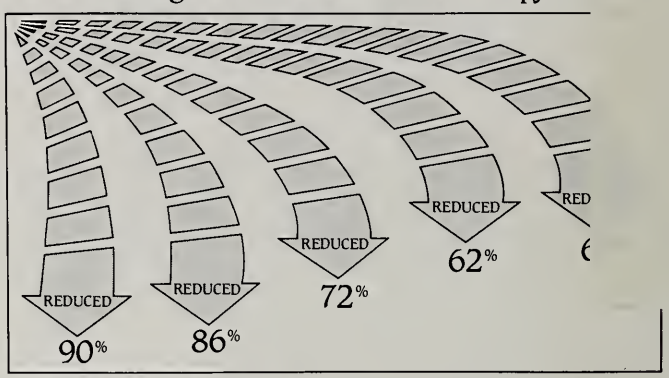
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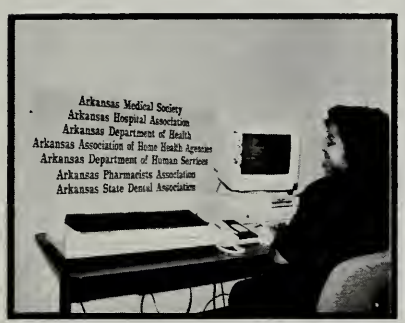
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Volume 86 Number 5 October, 1989

The Jonesboro Sun

New plan on health outlined

To help indigent



MEDICAL ECONOMICS-SEPTEMBER 4, 1989

ARKANSAS DOCTORS ADDRESS THE INDIGENT-CARE NEED



AMERICAN MEDICAL NEWS/AUGUST 4, 1989

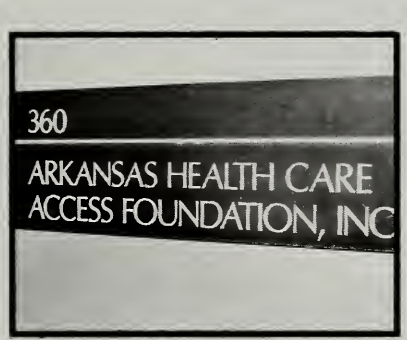
MDs to give free care in Arkansas indigent program





Batesville Guard

Coalition of doctors to offer indigent care in Arkansas



Arkansas Democrat Gazette

Plan offers needy free health care

Texarkana Gazette

In Brief

Doctors to offer free help to needy



The Sentinel Record

Coalition of state's doctors will provide indigent care

Springdale News

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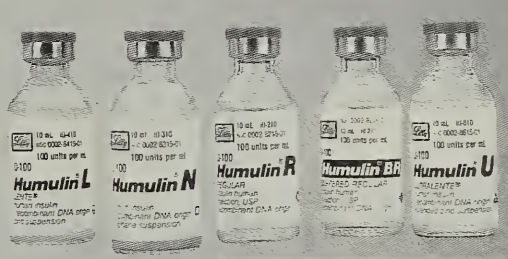
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Arkansas Physicians Care

Health Service Program Announced for Indigent Arkansans

Martha S. Taylor
Journal Managing Editor

Over two years of discussions and planning sessions culminated at a Little Rock news conference, Thursday, September 14, with the announcement of the start-up of the Arkansas Health Care Access Foundation. The Foundation will oversee the provision of medical, dental, and other health services for the indigent of Arkansas.

Dr. James Weber, Arkansas Medical Society President, told the group of radio, print and television reporters, and guests that the Foundation is a joint effort of voluntary organizations including the Arkansas Medical Society, Arkansas Hospital Association, Arkansas State Dental Association, Arkansas Pharmacists Association, Arkansas Association of Home Health Agencies, Arkansas Department of Health and the Arkansas Department of Human Services. The Foundation is the umbrella covering the separate entities of each group. The separate groups are calling their individual programs "Arkansas Physicians Care", "Arkansas Dentists Care", "Arkansas Pharmacists Care", etc.

"This is the largest number of volunteers and the most comprehensive range of health care professionals and organizations banding together for this type of program in the nation. Here is a clear example of Arkansas being in a leadership position," Weber said.

The program will match eligible indigents with a physician or dentist in their area who will see the patient free-of-charge for one visit with further visits to be arranged on an individual basis. To be eligible, the patients must be an Arkansas resident, have an income below the Federal poverty level and be ineligible for Medicaid assistance. It is estimated that there are between 300,000 and 400,000 Arkansans who will be eligible for the program. "Although the system is not perfect and it cannot provide all things to all people," Weber said, "it is designed to be of help to those people in need. This is a major effort to help those families with destitute financial circumstances gain access to the health care system through a caring professional."

Ken LaMastus, Executive Vice President of the Arkansas Medical Society, explained that persons can apply for the program by first visiting a local office of the Department of Human Services where an eligibility certification form will be completed. Copies of the forms of eligible recipients will be sent to the Foundation offices and entered in the computer system. When non-emergency medical attention is needed, the person calls the toll-free number and is referred to a volunteer primary care physician or dentist in his or her area. Dental services will consist initially of a screening evaluation and pain relief. Similarly, pharmacists, hospitals and home health care agencies will provide limited services free-of-charge.

LaMastus said the program was modeled after one in Kentucky which was begun in 1985. The Kentucky program was the first in the nation of its type but involved only physicians and hospitals. LaMastus pointed out that the Arkansas program is second in the nation and includes a much broader and comprehensive scope of care for the poor. Approximately 1,000 physicians, or one-third of the practic-

Program Director Sees Bright Future

After only four days of operation, Pat Keller, Director of the Arkansas Health Care Access program, has her hands full. There have been approximately 300 calls logged with inquiries about the program. "If it keeps up like this, I can safely say we have a big hit on our hands."



Before coming on board with Health Care Access, Keller was case management specialist with the Delta Counseling Associates in Monticello. Her duties there included arranging services for chronically mentally ill clients in Chicot County. Keller is a licensed practical nurse who has worked as a case manager at the Area Agency on Aging of Southeast Arkansas in Pine Bluff and was closely involved with the Women, Infants and Children Nutrition (WIC) program of the Public Health Department. **(continued next page)**

ing doctors in Arkansas, have volunteered for the Arkansas Physicial Care program and LaMastus indicated that they are expecting more physicians to join, possibly bringing the total up to one-half of Arkansas physicians.

"We have designed the program to be simple and efficient with no paperwork involved for any of the volunteers or their office staff," LaMastus added. After a physician sees a patient once, his name will be placed at the bottom of the referral list for his area, thus insuring he will not see more than his share of indigent patients. LaMastus acknowledged that the Delta region would be a problem area because there are few physicians and a large indigent population.

Weber and LaMastus said the program would never have gotten off the ground without the support and encouragement of Pine Bluff Senator Knox Nelson, Chairman of the Senate Public Health Committee, and Blytheville Representative Walter M. Day, Chairman of the House Public Health Committee. Both men sit on the Indigent Care Task Force which administers the Indigent Health Care Trust Fund, providing the funding for the project for two years. LaMastus said the program would receive approximately $112,000 for first year and $88,000 the second year.

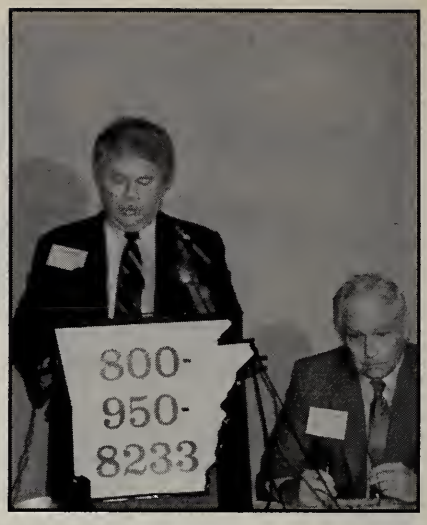


Ken LaMastus, AMS Executive Vice President answers questions at a Jonesboro news conference which was held Wednesday, September 17. Dr. Asa Crow of Paragould and and Senator Jerry Bookout of Jonesboro were also present.

Senator Nelson, making a statement for the press, said, "I do not know of any program that I've been associated with since I've been in the general assembly that I've been more pleased with than this program because of the good it's going to do for the people of this state."

During the news conference, LaMastus was asked about the danger of increased liability for participating physicians. He told reporters that during the last legislative session a "Good Samaritan" bill was introduced which was passed by both the senate and house; however, it was vetoed by Governor Bill Clinton. When asked if such a bill would be introduced again, Senator Nelson replied, "A Good Samaritan bill will be part of the legislative package as long as I'm there."

Herman Heard, D.D.S., a Pine Bluff dentist and representative for the Arkansas State Dental Association, said, "The primary objective of the program is that there will be no one in the state of Arkansas who needs dental care who has to go without that care."



James Weber, M.D., AMS President, presented the Arkansas Physicians Care program in Little Rock. Senator Knox Nelson was present to show his support.

Department of Human Services officer, Gordon Paige, added his support for the program. "We're extremely excited to work with the members of the medical society and the other entities in the health field. We currently serve 175,000 to 190,000 people who receive Medicaid services and we see twice that number for are not eligible for our services. This is a golden opportunity to provide health care services to the people. In terms of the mission of Human Services, that's what it's all about."

Director (continued from previous page)

Keller said that the Arkansas Physicians Care program will "fill a gap for those persons who, until now, have been without any options. My previous experience working with low income persons was disheartening at times because we had to turn people away. There simply were no programs available for some people." Keller added, "They couldn't understand why there was no help for them. That is why I feel very strongly about making this program a success."

Keller also stated that she felt the program would be of great advantage for nursing and social workers who work with the indigent on a daily basis. "This will give the nursing and social work professionals another avenue in which to serve the poverty-stricken in Arkansas," Keller said.

"I also want to emphasize that any physicians, dentists, or pharmacists who have not already volunteered for the program may still do so. We would welcome their involvement." Keller said the new volunteers can have their names added to the referral list by calling the Arkansas Health Care Access Foundation at 1 (800) 950-8233.

Assisting Keller in the administration of the program is Susan Rish. Rish's background includes being a legal coordinator assistant and a customer service representative at Blue Cross Blue Shield of Mississippi. Both Keller and Rish started work at the Foundation headquarters in the Arkansas Medical Society building in September.

EDITORIAL



The Greek Connection

John Olson, M.D.

Recently, a rather surprising number of patients from northwest Arkansas have gone to Greece to undergo treatment by a "Doctor" Heriton Alivizotas, who claims to have had discovered a cure for cancer some thirty years ago. Little do these unsuspecting people know that the American Cancer Society discredited his claims in a study done from 1975 to 1982.

Apparently he had previously been in business somewhere in Mexico and then moved to Greece.

Many of these people travel to Greece because of collections taken up by well-meaning friends, to cover the cost of the trip and his "treatment", which is quite expensive.

Apparently, this movement from our area of the state has metastasized from Oklahoma, probably by word of mouth. The number of patients lured to his base of operations from Oklahoma was quite great.

In an excellent article in the *Tulsa World*, July 16, 1989, the activities and methods used by Alivizotas were well documented and the description of this operation was detailed. I have personally interviewed one of my patients who took this trip and a large packet of information which she received was given to me. The patient is a highly intelligent middle-aged female upon whom I did a cancer operation on some years ago and she has been followed at frequent intervals. She has displayed no evidence of any recurrence, but according to his "testing", was told that cancer was in her lymph nodes. This, of course, is entirely fallacious.

A physical examination is not given by him and his treatment consists of daily injections of a "serum" for 16 to approximately 30 days. "Blood tests" are taken every six days which allegedly can detect the type of cancer and location in the body and how "well the treatment is working." The material injected is, of course, a "secret" but probably contains some foreign protein which causes a mild reaction making the patient feel like he or she is getting a strong medication.

Not only does he claim to successfully treat cancer, but also diabetes, arthritis and other diseases. One of our patients in this area was told that she had diabetes but was cured by his treatment. Of course, she did not have diabetes in the first place.

Some months ago, a TV station in Fort Smith unfortunately had a telecast interviewing patients with an oncologist giving a limited interview, which may have added some credibility to the treatment given by this quack. The majority of people who go are intelligent and probably go in desperation after conventional treatments have not produced the results they desire. These patients hardly ever seek the advice of a physician before taking this expensive and fruitless trip. Some have foregone the chance for cure by rushing over. Recently, a patient in this area had a biopsy of a lump in her breast which was proven carcinoma and mastectomy was planned. However, she chose to go to Greece and probably has deprived herself of an excellent chance for a cure by accepted treatment. One patient, hospitalized here following her trip, was told by her physician that the tumor had become much larger in spite of this so called "cure." This patient phoned Alivizotas and was told not to believe what her local doctor had said because the injections which he had given her were "working" and forming a "capsule" around the tumor so it would not spread.

Unfortunately, there has developed a feeling among certain people that cures for cancer are not forthcoming because doctors will make more money by suppressing a cure. What an ignoble thought this is! Every known method of treatment which promises help is published in ethical medical journals, available to anyone in the medical profession. None of the unorthodox forms of treatment as practiced by Alivizotas has ever been printed in a medical journal because, of course, there is no credibility to his methods.

What can we do as physicians to stop this travesty on human life and emotions? We can counsel people and tell them the truth as emphatically as possible. We can also offer to send them to cancer centers in this country if they so desire. Good moral support is very helpful, as a proper attitude by the sufferer will often help delay the progress of disease.

We wonder why the Greek government itself does not do something to irradicate this festering sore. Apparently, he was not allowed to treat Greek patients and has relied on his income source from patients outside his own country. If he was shut down the Greek government would, of course, suffer by losing the income from these patients spending their hard-earned money in Greece. Fortunately in this country we do have regulatory agencies which can put a stop to this malicious quackery.

AIDS IN ARKANSAS 1989
January 1 - September 13, 1989

Total number of cases reported	55
Number of deaths	28

CASES BY SEX

Male	49
Female	6

CASES BY RACE

White	41
Black	13
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	37
Homosexual & IV Drug User	5
IV Drug User	6
Hemophiliac	0
Transfusion	1
Heterosexual (Contacts)	5
NIR#	1

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	1
20 - 29	16
30 - 39	28
40 - 49	6
50 - 59	3
60 or more	1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	18
Kaposi's Sarcoma	2
Pneumocystis Carinii and Kaposi's Sarcoma	0
Other Diseases	35

AIDS IN ARKANSAS
1985 - 1989

Total number of cases reported	228
Number of deaths	143

CASES BY SEX

Male	211
Female	17

CASES BY RACE

White	176
Black	50
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	151
Homosexual & IV Drug User	27
IV Drug User	23
Hemophiliac	1
Transfusion	10
Heterosexual (Contacts)	12
NIR#	4

CASES BY AGE GROUP

Less than 20	3
20 - 29	74
30 - 39	102
40 - 49	32
50 - 59	9
60 or more	8

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	101
Kaposi's Sarcoma	10
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	111

No identified risk group (NIR)

Source: Arkansas Department of Health.

AMS Committee on AIDS William N. Jones, M.D. Chairman

Update: October 1989 Pentamidine Aerosol: Innovation, Experimentation and the Future

*William Mason, M.D.**

The September 1989 issue of this journal contained the Centers for Disease Control report titled, "Guidelines for Prophylaxis Against *Pneumocystis Carinii* Pneumonia for Persons Infected with Human Immunodeficiency Virus." As a followup to this report, I was asked by the Arkansas Medical Society subcommittee on AIDS to comment on the experience utilizing pentamidine aerosol in a community hospital in Arkansas. The Society has given me liberties to extend my comments beyond this experience and perhaps meander a bit, using pentamidine as a focal point. I sincerely hope the readers follow my train of thought and, though they may disagree with a few philosophical points, there should be no disagreement in the primary goal among us - delivery of the best medical care to our patients whatever their illness might be.

This article will tell you how a community hospital in Arkansas came to use aerosolized pentamidine two years before its approval by the FDA and then lead you through a University aerosol research center. Finally, I will conclude this story with brief comments on the future of scientific research in this country. And so I will begin.

In 1983, the first patient hospitalized in Arkansas with acquired immune deficiency syndrome was diagnosed at St. Vincent Infirmary Medical Center, a 690-bed referral center located in Little Rock, Arkansas. The patient died of complications of *Pneumocystis carinii* pneumonia and disseminated histoplasmosis. He had received intravenous pentamidine flown in from the CDC in Atlanta and amphotericin B. His disease and subsequent death at St. Vincent reached the news media which directed the public's attention towards AIDS as a new disease in Arkansas. Soon, this hospital was the primary private treatment center for many of the AIDS cases in Arkansas. They usually presented with *Pneumocystis carinii* pneumonia (PCP). Physicians were helpless as they watched their asymptomatic HIV-infected patients evolve into symptomatic, acutely ill individuals with PCP. By the time treatment for PCP was started, the patients' mortality had jumped to approximately twenty percent. Prophylaxis against PCP utilizing trimethoprim-sulfamethoxazole was used but rashes, nausea and other side effects seemed to interfere with its usefulness. Not much seemed to work to prevent PCP and it was very frustrating.

Then, in May of 1987, a patient's wife stopped me in the hall and told me about the studies of Dr. Bruce Montgomery at San Francisco General Hospital using inhaled pentamidine both as prophylaxis and treatment for *Pneumocystis carinii* lung infections. I called Dr. Montgomery later that week and he told me of the efficacy of inhaled pentamidine in the treatment of ***active*** PCP. He said his team had completed the inhaled pentamidine study in a remarkably short period of approximately seven or eight weeks and that the results were excellent. In fifteen patients with active PCP, thirteen responded to aerosol therapy with no systemic side effects. The study was to be published three to four months from completion of the experiment. In the course of his conversation, he emphasized the importance of the particle size of the pentamidine aerosol. At this point, however, my attention was wandering for I could have cared less about particle sizes...I wanted to get enough information to get our patients started on the inhaled treatment regimens. But before I could interrupt, he said, "In order to deliver the appropriate particle size of 1 to 2 micra necessary for alveolar deposition, our team at San Francisco General has invented an aerosol

"Physicians were helpless as they watched their asymptomatic HIV-infected patients evolve into symptomatic, acutely ill individuals with PCP. "

Dr. Mason is a pulmonary disease specialist in Little Rock and a member of the AMS Committee on AIDS. Write him at 610 Freeway Medical Tower, Little Rock, Arkansas 72204.

delivery system which allows a continuous delivery of standardized particles. We've come up with a device which contains baffles to break the particles down and keep them at the right size. It also contains a filter to prevent escape of the pentamidine to room air thus lessening contamination of the room environment.'' Dr. Montgomery said that these devices were initially manufactured within their hospital for patient use but were now commercially available under the name Respirgard II. He was convinced that aerosolized pentamidine was effective not only in the treatment of active PCP, but also as a prophylactic drug to prevent PCP's occurrence. I told him that the number of AIDS cases in Arkansas was small compared to San Francisco's, but we were very interested in our patients getting the most effective treatment or prophylaxis possible. Through Dr. Montgomery's generosity, we were able to obtain copies of the pentamidine study protocols. The protocols were reviewed and with the help of Ms. April Jackson, a superb R. N., we presented a two-phase study of aerosolized pentamidine, which included treatment and prophylaxis, to the Investigational Review Board at St. Vincent. The protocol was approved on June 30, 1987 and our first patient was treated immediately. The publication of Dr. Montgomery's work using pentamidine in the treatment of PCP appeared two months later in the August 29 issue of *Lancet*. By that time, we had several patients enrolled in the studies.

At this point I should mention that the treatment plan described above was discussed with the administration at St. Vincent. The administrators approved the project fully knowing that the financial undertaking could prove formidable. The hospital was already under stress from significant losses under the DRG-Medicaid system; yet, administration felt it was a part of the hospital's ''mission'' to provide physicians on the staff with any medication which might be effective for use in their patients with AIDS. Eighteen months later in December 1988, the hospital had not only purchased $60,000 worth of pentamidine but also had provided nursing personnel, hospital space, equipment, etc., for the inclusive treatment. Charity patients comprised about one-third of those treated. The physician staff were impressed at the hospital's effort and noted that never once did it back away from its commitment.

Our studies with 300mg of pentamidine inhaled twice monthly as a prophylactic agent were completed in July 1989. At that time patients were changed to the 300mg dose every four weeks as recommended by the CDC and approved by the FDA. Analysis of the 300mg twice monthly prophylaxis data is not yet available; however, we have no reason to doubt its general effectiveness. Our studies continue using inhaled pentamidine, 600mg daily, as a *primary* treatment modality for active *Pneumocystis carinii* pneumonia. Thus far twenty-two patients have been treated and analysis of patient data appears favorable. Time and further analysis will tell.

Pentamidine is the first medication in the history of medicine to effectively prevent and probably eradicate an infectious process utilizing exclusively the aerosol route. It has opened a whole new world for exploration of more effective methods for the delivery of aerosols. Pharmaceutical companies are studying novel aerosol delivery systems which when developed will seem unique and strange to the physician of the 1980's. The physicians of the 21st century will quite likely be as familiar with the physical characteristics of aerosols, their mass median aerodynamic diameter, and electrostatic charge, as we are about the serum concentrations of oral and parenteral drugs.

Until aerosolized pentamidine was available, I had little interest in aerosols even though I ordered them daily in the form of metered dose inhalers containing bronchodilators, beclomethasone, cromolyn sodium, etc. But I found one individual who not only has an interest in aerosols, but has been pursuing aerosol research in Arkansas - Dr. Malay Mazumder, director of the Department of Electronics and Instrumentation at the University of Arkansas at Little Rock. Unfortunately, scientists are in a constant struggle for adequate financing of their projects. As an example, Dr. Mazumder and another engineer in his department, Ron Ware, developed a laser machine to measure the aerodynamic diameter and electrical mobility of aerosols on a single particle basis. They called this invention E-SPART - a device that can be set up in a room to count, in real time, the number of particles floating around and their electrostatic charge. In the right hands, it could be modified to do a variety of tasks. Just use your imagination. Yet in 1979, engineers Mazumder and Ware could find ***no U. S. companies interested in underwriting its continued development.*** When Dr. Mazumder gave a lecture in Japan about the E-SPART concept, he was immediately contacted by a Japanese com-

"There have been many sacrifices among our fellow health care workers and researchers in order to study and to care for the victims of AIDS; fortunately only a few have acquired the infection in the course of their work. Many others have suffered psychologically, from fears of contracting the disease to the emotional depletion of watching young people die. "

"History will show that medicine rose to meet a great challenge."

pany, Hosokawa, which subsequently obtained the sole marketing rights to this invention. At this time, there are twenty E-SPART's in use in the Japanese powder industry (which includes toner powder for office copiers, etc.) and only one in the United States. Do the Japanese know more about the potential of aerosols than our country? It makes me wonder if our aerosol technology might suffer the same fate as did the video cassette recorder industry decades ago when the American business industry ignored the development and potential of the VCR. Presently I know of no company manufacturing VCR's in the United States. Recently, Fujisawa, a large Japanese pharmaceutical company, completed the stock purchase of 70% of Lyphomed, the company which manufactures pentamidine, the drug I have been discussing.

How then does all of this tie in with the treatment of a single patient with AIDS? Because as a Jesuit priest once told me, "Everything is tied to everything else." Without the innovation and inventiveness of people like Dr. Montgomery many of our patients with AIDS would have had their lives shortened by months or years. Without solid institutions of health care delivery such as St. Vincent Infirmary Medical Center, which was willing in 1987 to undertake a program which carried with it a potentially significant financial burden, our patients would have had no means for receiving the best treatment for a deadly disease. Without pharmaceutical companies willing to take chances on research and development of new drugs, while modifying old drugs such as the orphan pentamidine, adequate treatment of the most common opportunistic infection in patients with AIDS might have been delayed for years.

There have been many sacrifices among our fellow health care workers and researchers in order to study and to care for the victims of AIDS; fortunately only a few have acquired the infection in the course of their work. Many others have suffered psychologically, from fears of contracting the disease to the emotional depletion of watching young people die. I see all these people as the unknown heros of medicine.

History will show that medicine rose to meet a great challenge, the plague of AIDS, and that our profession did not shrink from its responsibility. We met the epidemic using every instrument of technology available while evaluating drugs in as rapid a fashion as good medicine would allow. I am confident that in time we will not only destroy this virus in the body, but that a vaccine will be developed to prevent its spread. Immense spinoffs beneficial to the treatment of many other diseases will come out of all this knowledge.

Our nation can accomplish such enormous tasks only through the continued efforts of scientists, physicians, nurses, and others in advanced health care institutions. A certain fragility is present today in all the links of our health care chain so, as a nation, we must fortify our scientific and health care resources if we are to successfully win today's battle while preparing for tomorrow's epidemics.

Suggested Reading

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3. Andrulis DP, Beers VS, Bently JD, et al. The provision of financing of medical care for AIDS patients in U.S. public and private teaching hospitals. JAMA 1987; 258:1343-6.
4. CDC. Guidelines for prophylaxis against *Pneumocystis carinii* pneumonia for persons infected with human immunodeficiency virus. MMWR 1989; 38(sup. 5):1-9.
5. Renninger RG, Mazumder MK, and Testerman MK. Particle sizing by electrical single particle aerodynamic relaxation time analyzer. Rev Sci Instrum 1981; 52(2):242-6.

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SPECIAL ARTICLE

A Letter from the Arkansas Foundation for Medical Care, Inc.

Morton C. Wilson, M.D
Chairman, AFMC Board of Directors

Editor's Note: The quarterly meeting of the Board of Directors of the Arkansas Foundation for Medical Care will be held in Little Rock at the Holiday Inn West at 9:00 a.m., Saturday, November 18. This and other meetings of the Board of Directors will be open to the general membership of the Foundation.

Dear Fellow Physicians:

I am writing this article in my capacity as newly-elected Chairman of the Board of Directors of the Arkansas Foundation for Medical Care, the peer review organization for the state of Arkansas. We hope this will be a regular monthly feature of the *Journal of the Arkansas Medical Society* under the guidance of Dr. David Busby, Medical Director of the PRO. The monthly articles will be similar to the column written monthly by Mike Mitchell, the legal counsel for our state society.

Our purpose is three-fold:

1. To keep Arkansas physicians fully informed about the workings of their PRO;
2. To keep them informed about the new HCFA regulations and changes as they occur;
3. Above all, to encourage participation in the PRO by its constituent members.

The new administration of the AFMC has, as I perceive it, several major immediate objectives:

1. The actual inner workings of the organization will be closely supervised by a group of appropriate committees composed of members of the Executive Committee, the Board of Directors, and an at-large representative from the membership of the Foundation (i.e., one who is not an officer in the PRO). This hopefully will avoid concentration of power in any one individual or group. This, again hopefully, will maximize participation by members in the actual workings of their organization. These committees will be responsible to the Board of Directors which in turn remains accountable to the general membership. Dr. Don Howard chairs the Committee on Committees whose function is to establish these groups as well as to define their responsibilities.
2. The Medical Director will report directly to the Board of Directors rather than to the Chief Executive Officer, thus avoiding a situation which proved to be a source of difficulty in the recent past and a potential source of trouble in the future if left unchanged.
3. Participation on the actual workings of the organization will be more open and accessible to the general membership. To encourage attendance at our quarterly meetings, the Board meetings will remain open to the membership and the dates will be set up at quarterly intervals, two of which will coincide in time and location with the annual and winter meetings of the Arkansas Medical Society.
4. The bylaws will be modified to streamline the election process, making it easier for members to hold office.
5. Balloting by mail will be recorded as either an "aye" or "nay" vote. Ballots not returned in the mail will be considered as abstentions, not a positive votes!
6. Medical review committees will be composed of members of the Foundation who are physicians practicing in the state of Arkansas but hold no office in the Foundation. A member of the Board of Directors will be a nonvoting observer at each meeting. The possibility of subjecting the physician to double jeopardy, thus, will be avoided.

In subsequent communications in the *Journal*, Dr. Busby will go into more detail concerning these committees.

True peer review is a reciprocal relationship of practicing physicians reviewing their peers and they, in turn, being reviewed by their fellow physicians.

The Annual Meeting of the Arkansas Foundation for Medical Care at Little Rock recently proved beyond doubt the political clout of Arkansas physicians in running their PRO along democratic lines. Over 100 physicians were present on the Memorial Day weekend, a time we traditionally devote to recreation with our families. Many traveled long distances at great sacrifice of time and expense. I hope that we will continue to keep up this level of interest.

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All inquiries are confidential within the Committee and no names or locations are necessary when contacting the Society office.



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Intervention Services for Developmentally Delayed Infants and Toddlers in Arkansas

E. W. Ashcraft, M.D., Patrick H. Casey, M.D., and Tom Nosal, L.C.S.W.*

Editors Note: This is the last of a three-part series on special education in Arkansas and its implications for the physicians of the state.

In October of 1986, United States Congress passed Public Law 99-457, the 1986 amendments to the Education For All The Handicapped Act. This new law represented the first major federal legislation affecting early intervention for infants and toddlers (ages 0 through three) with developmental delays or disabilities. This law provides financial support to state governments to assist them in developing and implementing services for handicapped infants and toddlers; it also requires states to begin, within five years, to serve all eligible handicapped children from birth to three years of age as a condition for receiving continued federal support.

The stated rationale for Public Law 99-457 is that early intervention services for handicapped children will: 1) enhance the development of individual infants and toddlers; 2) reduce the educational costs to society; 3) minimize the likelihood of institutionalization; and 4) enhance the capacity of families to meet the needs of their handicapped infants.

The law authorizes states to plan, develop, and implement over a four year period a system which is a "statewide, comprehensive, coordinated, multi-disciplinary interagency program of early intervention services for handicapped infants, toddlers, and their families." Children to be included are "infants from birth through age three years who are in need of early intervention services because they are experiencing developmental delays or have a diagnosed physical or mental condition which has a high probability of resulting in a developmental delay." It is also the state's discretion to include children who are at risk, biological or environmental, of having developmental problems. The states are mandated to designate a lead agency and to establish an Interagency Coordinating Counsel for planning to determine their own definition of developmental disabilities and their systems of identification, evaluation of disabled infants, and the intervention model. The federal legislation also requires that an individualized family service plan (IFSP) be developed by a multi-disciplinary team for each child and family enrolled in the intervention program. The IFSP requires that specific child and family goals be articulated and plans for implementing and monitoring be developed. Intervention services are defined as "developmental services designed to meet a handicapped infant's developmental needs in any one or more of the following areas: physical development, cognitive development, language development, psychosocial development, or self-help skills." The legislation also requires that participating states develop formal due process procedures, under which parents can appeal the evaluation or placement of their children.

Arkansas Act 658 of 1987 designated the state Developmental Disabilities Services (DDS) as the lead state agency. Governor Clinton appointed an interagency coordination council consisting of 15 members; this council has met on several occasions since August of 1987 and has accepted a working definition of the Arkansas target population of infants and children. This includes the following:

a) Children who are experiencing "developmental delays"; children who have been diagnosed by a multi-disciplinary team as having a significant delay in one of the following areas of development: cognitive, speech/language, physical/motor, vision, hearing, psychosocial, or self-help skills, or
b) Children who have a "diagnosed physical or mental condition which has a high probability of resulting in a developmental delay; i.e. Downs syndrome, genetic disorders, microcephaly, metabolic disorders, congenital anomalies, neonatal seizures, asphyxia, sensory impairment, or maternal acquired immune deficiency syndrome, or
c) Children who are "at risk of having substantial developmental delays if early intervention services are not provided; i.e. CNS trauma, CNS infection, seizure disorders, prematurity, interventricular hemorrhage, failure to thrive, or child abuse.

This definition of the target population was used in 1988 during a statewide competition for pilot projects submitted in response to proposals from the Interagency Coordinating

Assistant Professor of Pediatrics, University of Arkansas for Medical Sciences/Arkansas Children's Hospital, Clinical Director, James L. Dennis Developmental Center, 1612 Maryland, Little Rock, Arkansas 72202.

Table I. Early Intervention Services

Age	Service Program	Target Population
0-2 Years	Developmental Disabilities Services Program	Any Child with Developmental Delay
	Early Intervention Pilot Projects (PL 99-457)	a. Children experiencing or diagnosed with cognitive, speech/language, physical/motor, visual, hearing, psychosocial, or self-help skill delay b. Children with diagnosed physical or mental condition which has high probability of developmental delay c. Child at risk of developmental delay if early intervention not provided
3-5 Years	Developmental Disabilities Service Program	Children with documented mental retardation
	Public School 3-5 Year Program (PL-457)	a. Noncategorical (impaired cognitive, communication, fine motor, gross motor, or social/emotional function) b. Speech or Language Impaired c. Orthopedically Impaired d. Hearing Impaired e. Other Health Impaired f. Multihandicapped g. Visually Impaired
	Head Start Program	Same as Public School 3-5 Year Program

Council. A summation of the early intervention grant recipients and the summary of services provided are included in Table I.

Likewise, there are a variety of early intervention programs that are receiving state funds through Developmental Disabilities Services. These funded programs do not receive Title XX funding; these programs do provide in-home training for parents. A summation of these programs are listed in Table II. Any child with any developmental delay can be referred to a local Developmental Disabilities Services structured preschool program. By age three, these children must undergo formal psychometric evaluation to determine whether or not the child is mentally retarded. If the child has "graduated" based upon psychometric evaluation, the child will no longer be served in a Developmental Disabilities Services. Options for these children include referral to local Head Start programs or to the aforementioned educational co-ops. Should the child demonstrate mental retardation based upon psychometric evaluation, the local DDS center can continue to provide services for that child.

In addition, there are 41 other developmental disability centers throughout the state that provide structured preschool services for children 0-5 years of age. These programs do not provide in-home early intervention services.

Referrals to the early intervention services can be made in any one of the following ways:

1. Referral directly to the Developmental Disabilities Services community program.
2. Referral to the Client Support Services Section of Developmental Disabilities Services (968-8689). This unit will refer one of the DDS field counselors in the appropriate geographic area who will meet with the family and discuss available services and will then refer to the appropriate community program to provide services.
3. Contact the local Department of Human Services office for direct referral to the DDS field counselor. If the counselor is not housed in that particular county office, the county administrator will be able to provide the telephone number and location of the counselor serving that area.

Depending upon the circumstances, it may help to facilitate the process if the field counselor is first involved. However, if the physician is familiar with the local Developmental Disabilities facility, he/she may feel more comfortable with a direct referral to the field counselor.

In addition to the 0-3 population, Public Law 99-457 has also mandated that state education departments be required to bring service provision to the 3 to 5-year-old special education eligible, handicapped population. The State Department of Education and the local school districts are currently developing these programs throughout the state. At present, there are several educational cooperatives that are now in effect that are serving the 3 to 5-year-old population. A list of these co-ops can be obtained by contacting the author.

Referral to 3-5 year old program can be made to either of the following agencies:

1. Early intervention coordinator for the State Department of Education (Mary Kay Curry, (501) 682-4222);
2. Educational co-op serving the particular county where the child lives;
3. Local Educational Authority (LEA) supervisor for the area.

The proposed transition for children at age three involves transitioning planning six months prior to the child's third birthday. However, if the child will transition into a Head Start program or a 3-5 early intervention program, the Department of Education standards indicate children who are not three on or before October 1st cannot be served until the following October 1st. It is therefore being proposed that children currently enrolled in the 0-3 program continue to be served until they can be transitioned into the 3-5 program (conceivably to be served until age four), when transitioning will occur.

If the child reaches age three and has progressed sufficiently to be placed in a regular day care or preschool program, transition planning will begin approximately at age two and one-half years with placement at age three. The same procedure will be followed should it be determined the child would best be served in a Developmental Disabilities community program.

Referral from the 0-3 population can be referred to the local Head Start programs. At present there are 128 centers in 67 counties in the State of Arkansas. Four-year-old children have priority with the exception of three-year-olds who have handicapping conditions. The Head Start objective is to achieve at least 10% enrollment of children with handicapping condition in each program; these handicapping conditions include speech impairment, health impairment, specific learning disability, physical handicap, mental retardation, seriously emotionally disturbed, hearing impairment, visual impairment, deafness and blindness.

Table II. Early Childhood Coordinators

Judy Clay Arch Ford Education Service Cooperative 209 South Baramore Morrilton, AR 72110 354-2269	Janet Bruns N.W. AR Education Service Cooperative 409 North Thompson Post Office Box 204 Springdale, AR 72765 756-2803
Judy Davis-Dorsey Arkansas River Education Service Cooperative 221 South Beech Pine Bluff, AR 71601 354-6129	Diana Cunningham Ozark Unlimited Resources Coop. 322 Industrial Park Road Post Office Box 1990 Harrison, AR 72602-1990 741-3999
Vera Breeding Crowley's Ridge Educational Cooperative Post Office Box 377 Harrisburg, AR 72432 578-5426	Paula Bell Pulaski County Education Cooperative Post Office Box 687 N. Little Rock, AR 72115 758-3545
Sue Porter Dawson Education Service Cooperative 1021 Henderson Arkadelphia, AR 71923 246-3077	Pat Reese South Central Service Cooperative 400-B Maul Road Camden, AR 71701 836-2213
Jeri Brock DeQueen/Mena Educational Cooperative Post Office Box 110 Gillham School Road Gillham, AR 71841 386-2251	Joyce Riley S.E. AR Education Service Cooperative UA, Monticello (UAM) Post Office Box 3507 Monticello, AR 71655 367-6848
Jenny Garrison Great Rivers Cooperative Post Office Box 2837-G West Helena, AR 72390 338-6461	Karen Massey Southwest Arkansas Cooperative 513 East Shover Hope, AR 71801 777-3076
Donna Sheppard Northcentral Arkansas Education Service Center Post Office Box 739 Melbourne, AR 72556 368-7955	Karen Mantooth Western Arkansas Cooperative Route 1, Box 104 Branch, AR 72928 965-2191
Jerry Neumeyer N.E. AR Educational Cooperative Mailing Address: Early Childhood Center Route 1, Box 30 Paragould, AR 72450 239-2778	Becky Baldwin Wilbur Mills Education Service Cooperative Post Office Drawer 1016 Arkansas State University, Beebe Beebe, AR 72012 882-5467

There are innumerable challenges and obstacles facing the implementation of Public Law 99-457 including definitions of eligibility, funding, personnel and the development of new service models. One particular problem is that of the "environmental-risk category." At present, there is no universal agreement on what constitutes environmental risks; the definitions and restrictiveness of what is environmental risk may be subject to debate over time. There is an inherent danger that states may unduly restrict eligibility criteria to reduce the recognized population that must be served and the resulting program costs. On the other hand, a definition of environmental risk may be too broad and can result in "labeling" of children. This in turn can lead to discrimination against poor and minority families.

The challenges of Public Law 99-457 will indeed require input from all physicians of our state in the development of an optimal delivery system. This will be particularly challenging in a poor, rural state such as Arkansas. We as physicians must continue to be deeply involved with the evolution of early intervention services. As caregivers and advocates to our patients, we are mandated to provide input to the state legislature and to the Interagency Coordinating Council to develop an optimal, workable system for this state.



ELECTROCARDIOGRAM of the MONTH

William C. Furlow, M.D.
John W. Watson, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

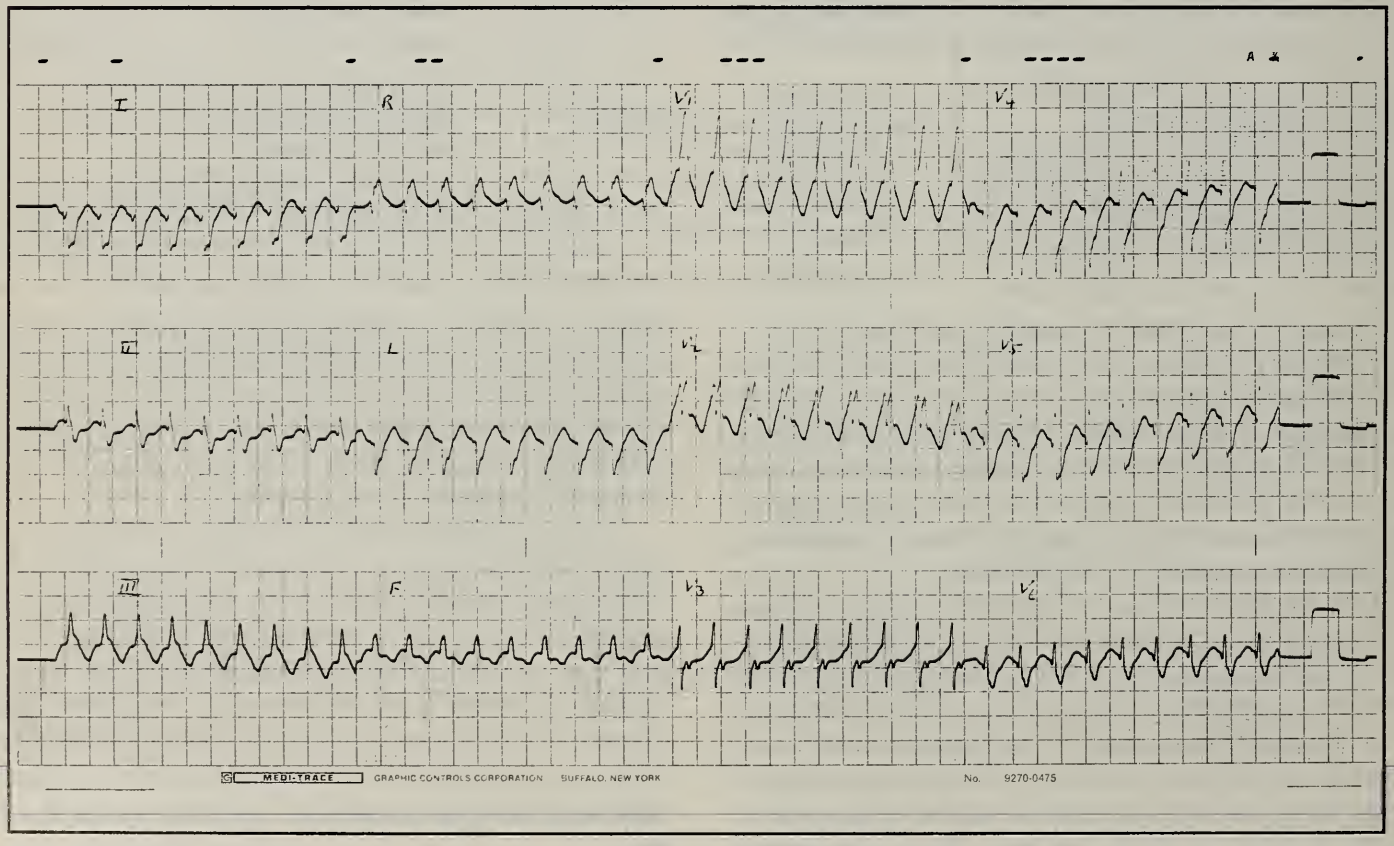
CLINICAL HISTORY:

W. R. is a 56-year-old man with along history of palpitations, presenting to the hospital because of chest pain, shortness of breath, and nausea. Examination of the heart and chest revealed tachycardia, a gallop sound, and crackles in the lungs. The chest film showed pulmonary edema. The electrocardiogram is shown. What do you think about the trace and the various options for treatment?

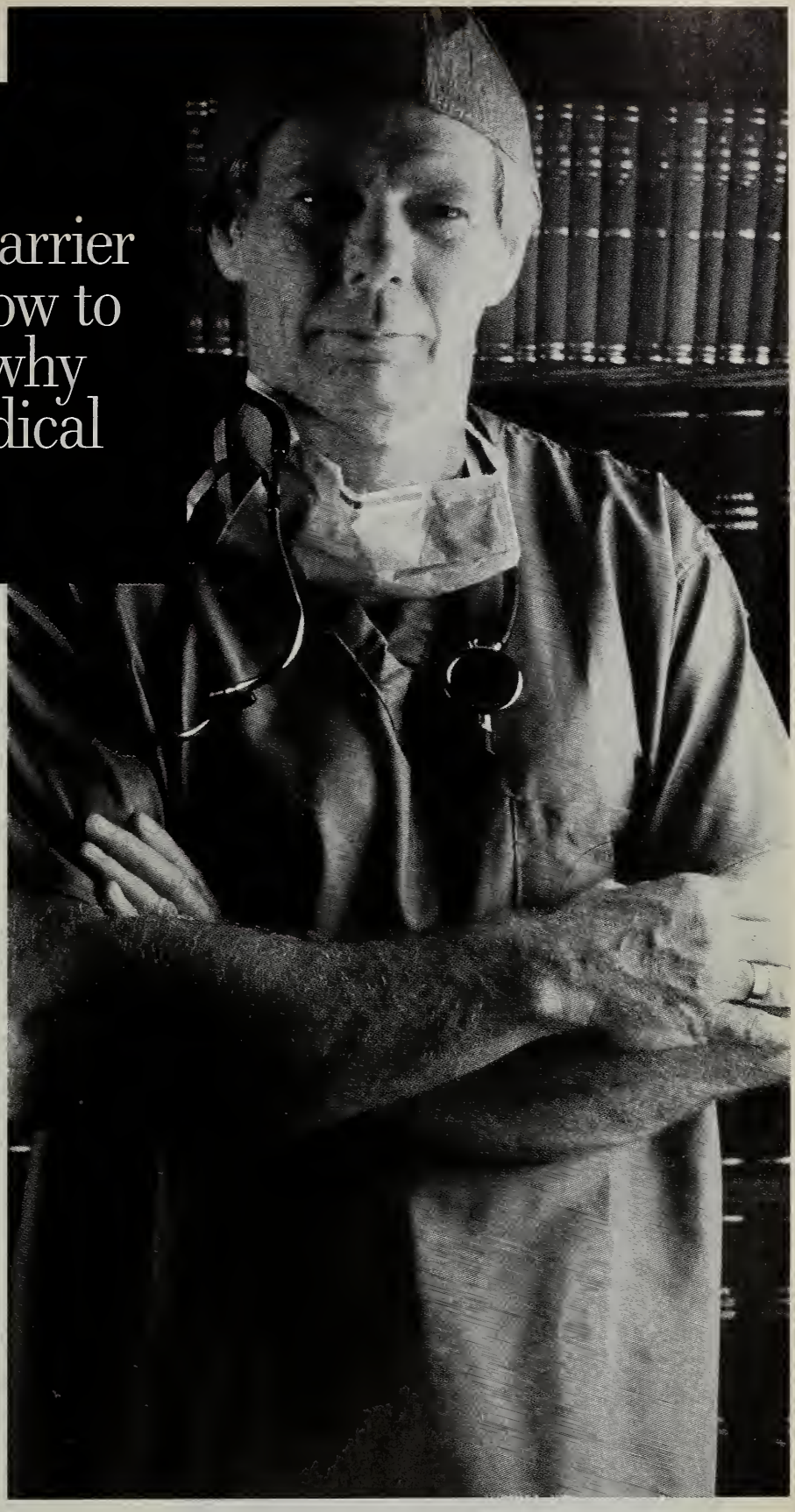
DISCUSSION:

The patient has a regular tachyarrhythmia at 214 beats per minute. The QRS duration is less than 0.12 seconds. A right bundle type conduction pattern is present, though complete block of the right bundle branch appears not to be present. P-waves cannot be seen with certainty but their presence is hinted at in several leads. Several features thus are present to suggest supraventricular tachyarrhythmia. The patient's well being is compromised, so expedient measures to the arrhythmia should be taken. Electrical therapy should stand high on the list of therapeutic options.

The feature editor wishes to thank Dr. Furlow of Conway, Arkansas for his help with this month's electrocardiogram.



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Computer Angiotomography of a Bleeding Intracranial Aneurysm

Joseph S. Murphy, M.D., Edgardo J. C. Angtuaco, M.D., James B. Blankenship, M.D., and Stevenson Flanigan, M.D.*

Introduction

A unique case is reported in which high resolution intracranial CT showed active bleeding into a temporal lobe hematoma with concurrent visualization of the responsible middle cerebral artery aneurysm. This CT angiotomogram served as the only preoperative diagnostic study.

Angiographic demonstration of aneurysm is well documented in the literature.[1] Three earlier case reports of aneurysmal rupture during computed tomography have also been reported.[2-4] We present the first reported CT demonstration of both a proven intracranial aneurysm and active bleeding associated with it.

Case Report

A 59-year-old woman was taken to her local medical doctor by her family after being found unresponsive. The patient had complained of a right frontal headache over the previous two days which had progressively worsened. The patient's past history was negative for hypertension.

General physical exam on presentation at our emergency room revealed on obtunded patient with a fixed and dilated right pupil and reactive left pupil. She demonstrated brisk bilateral decerebrate posturing. Her blood pressure was 160/80 with a heart rate of 74. She had spontaneous respirations with a rate of 32. Laboratory data including hematocrit, platelet count, PT and PTT were all within normal limits.

The patient was intubated and taken for an emergency CT scan of the head. The pre-contrast axial CT revealed a large hematoma in the region of the right sylvian fissure and temporal lobe (Figure 1A). Post contrast high resolution thin section angiotomogram showed two sites of abnormal enhancement. A focal area of intense enhancement was seen in the antero-medial portion of the high density hematoma and was felt to represent an active site of bleeding (Figure 1B). A second area of enhancement at the level of the right sylvian fissure was continuous with the right middle cerebral artery and represented a berry aneurysm of the middle cerebral artery at its bifurcation (Figure 1C). Due to the patients poor clinical status, she was taken immediately to the operating room for evacuation of the intracranial hematoma and clipping of the aneurysm.

In the operating room a right frontotemporal craniotomy was performed. Upon opening the dura, the brain was noted to be extremely edematous with subarachnoid blood present. The arachnoid was opened over the Sylvian fissure and a 4 x 4 cm hematoma in the temporal lobe was identified. At the base of the hematoma a branch of the MCA was identified and followed distally where a 6 x 8 millimeter aneurysm was found. No active bleeding was encountered and at the dome of the aneurysm a small fibrin plug was noted. The aneurysm was completely dissected and a triangular clip placed across its base.

The patient had a slowly progressive postoperative course. She remained normotensive throughout her hospitalization on no blood pressure agents. An arteriogram obtained one week after surgery showed no residual aneurysm. A post

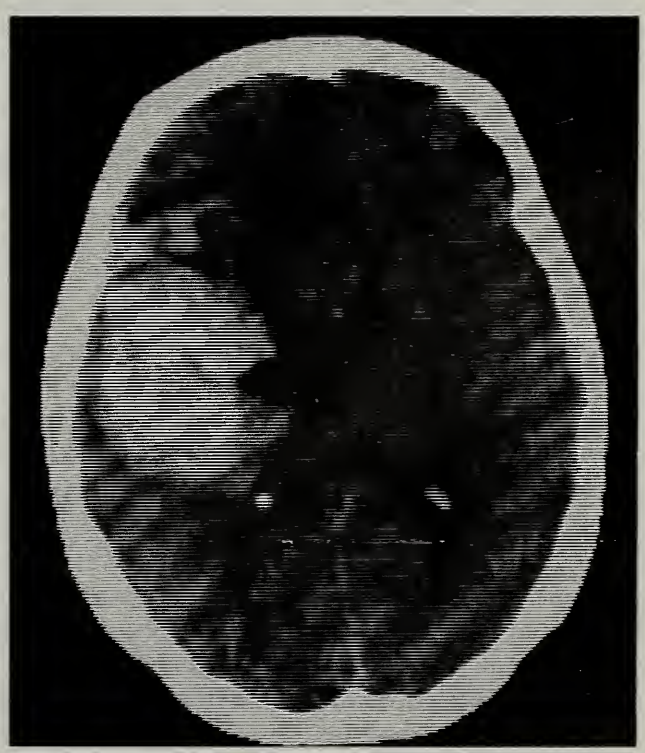


Figure 1A. Precontrast axial CT scan shows an area of increased density in the right temporal lobe and sylvian fissure with associated mass effect.

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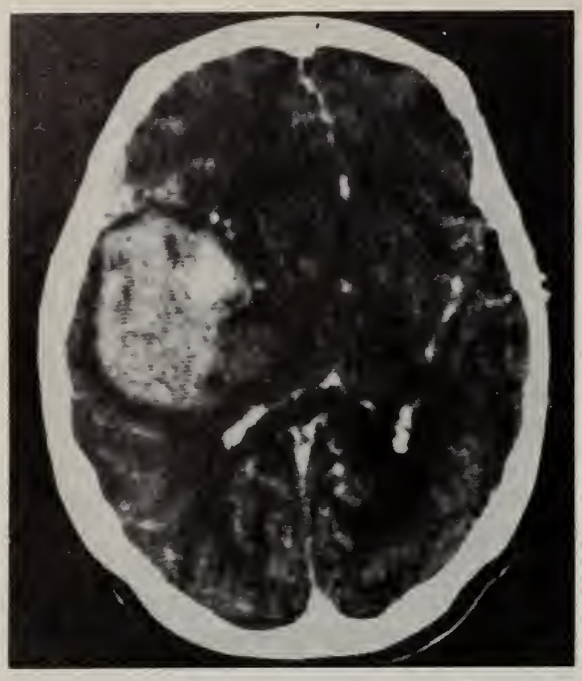


Figure 1B. CT angiotomogram at this same level shows a focal area of enhancement in the antero-medial portion of the high density hematoma.

operative CT showed resolving hematoma with no further hemorrhage. At the time of this publication the patient is verbalizing appropriately; she remains hemiparetic on the left but has regained total use of her right side; and exhibits a pupillary sparing right third nerve palsy.

Discussion

Early attempts at CT antiotomography were unsatisfactory secondary to slow scanning and low CT resolution.[5] Technical advances in the latest generation CT scanners with faster scanning times and thin-section high-resolution techniques combined with rapid dose contrast bolus allowed distinct identification of the small vessels of the Circle of Willis.[5-8] Asari and Yamamoto using CT angiotomography visualized both normal and abnormal cerebrovascular anatomy.[9,10] Our case illustrates the usefulness of this technique in identifying the responsible aneurysm causing the subarachoid hemorrhage.

While the latest generation of scanners has markedly increased the diagnostic yield of high resolution thin section angiotomography, certain pitfalls remain. Patient motion remains a problem although this is lessened by the faster scan times and shorter intervals between scans. True allergy to iodinated contrast often preclude its use and even minor side effects lead to errors in administration of the all important bolus infusion technique. Lastly, abnormalities less than 3mm in size are at or below the resolving capacity of even our best scanners and therefore may be missed.

High resolution thin section dynamic angiotomography has been used in the evaluation of vascular occlusion, Moyamoya disease and chronic subdural hematoma. Its greatest contribution however, has been in the evaluation of intracranial aneurysms both ruptured and unruptured.[7] Our technique is as follows. Both before and after the I.V. injection of 100 cc of 60% meglumine Diatrizoate 10mm sections are taken from the base of the skull to the to of the head in the axial projection. Ultrathin sections (2.0mm) encompassing the circle of Willis are then performed following multiple repeat bolus infections of 60% meglumine Diatrizoate. Contiguous 2.0 mm sections are obtained to encompass the supraclinoid internal carotid artery and its branches. The study is done with the highest spatial resolution available on the scanner. Direct coronal scans are performed when necessary and clinically feasible. Window and level settings are individually set to distinguish the dense subarachnoid blood from the contrast enhanced vessels. Magnified images are helpful in identifying the various structures in these sections.[6] There is currently no direct evidence to suggest that either angiographic or angiotomographic contrast infusion has led to an intracranial complication.[1]

This case exemplifies the utility and practicality of high resolution thin section CT angiotomography. CT angiotomography identified the right middle cerebral aneurysm causing the subarachnois hemorrhage. In addition, the study demonstrated an active area of bleeding from the aneurysm shown by a separate focal area of enhancement superior to the site of the aneurysm. In our critically ill patient these findings led to early and prompt operative evacuation of the blood clot and clipping of the aneurysm. Although this technique is not meant to supplant the need for preoperative arteriography it may, as in this case, serve as the final preoperative study.

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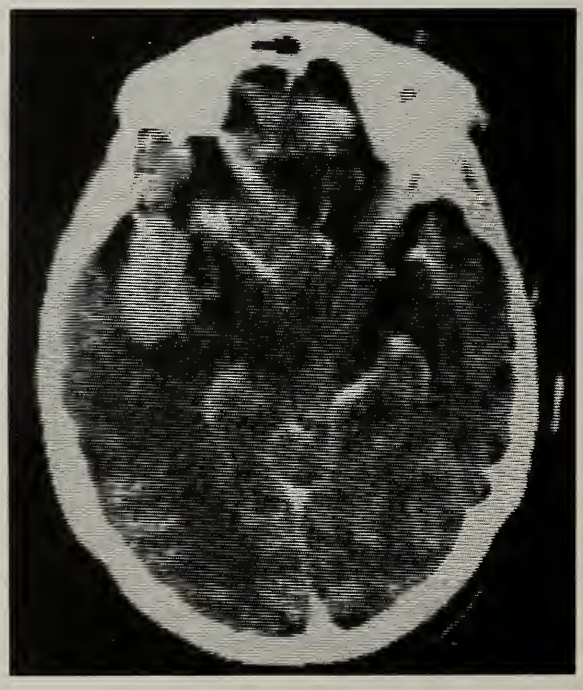


Figure 1C. At a lower level through the suprasellar cistern, CT angiotomogram shows an aneurysm at the bifurcation of the right middle cerebral artery.

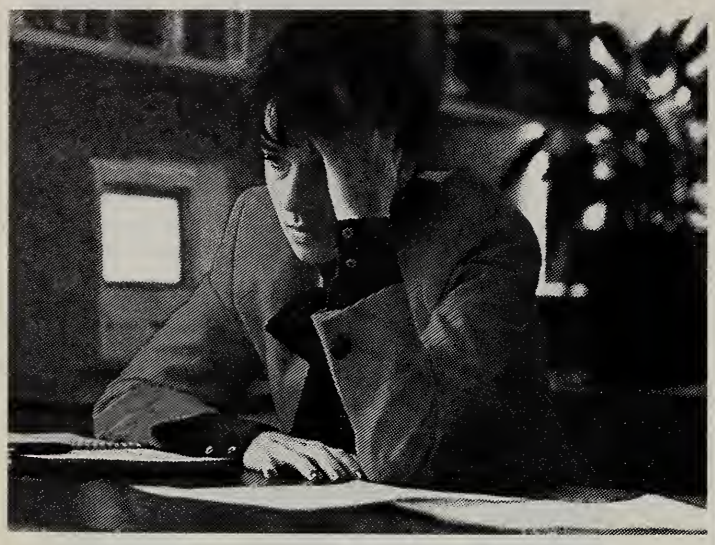
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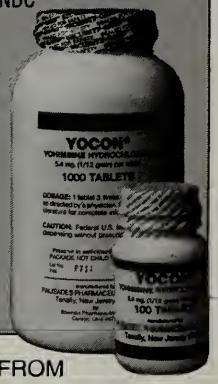
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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The Medical Assistant: Your Partner in Professionalism

*Ima Lou Backstrom, C.M.A.**

Introduction

Yesterday's "office girl" has evolved into a skilled professional - the medical assistant. Medical assistants are multi-skilled people dedicated to assisting in patient care management. The medical assistant performs administrative clinical duties under the physician's supervision in medical offices, hospitals and other health care facilities. The receptionist who greets patients as they walk into the office, the person who helps the patient prepare for an examination or the person who asks the patient for a urine sample or takes blood for analysis are all medical assistants.

Role of Medical Assistants

To patients and families, the medical assistant symbolizes "the doctor's office", and lays the foundation for their perceptions of the medical care they will receive. Whether they feel comfortable and confident or misunderstood and unwelcome will depend to a very large extent on the image that is projected by the medical assistant. Often, a medical assistant is the first person in the medical office that a patient encounters. That first impression will weigh heavy on the patient's feelings about the office and level of confidence in the physician. Therefore, the professional medical assistant must possess human relations skills which will enhance the physician's medical skills.

In the role of an administrative assistant, patients are informed about appointment schedules, billing, insurance services, telephone hours and how to reach the physician before and after office hours. This helps establish an understanding between the office and patient, and gives the patient added confidence to ask questions. Patients often feel intimidated in addressing questions directly to the physician, so the role of the medical assistant in transmitting questions to the physician is of vital importance.

The medical assistant is also your partner in patient education. Often, when we think of patient education, we think of patients learning more about diseases and conditions. However, patient education applies to many aspects of health care and the skilled medical assistant can play a major role in patient education thereby conserving the physician's valuable time. In the role of clinical assistant, the patient is educated by the trained medical assistant explaining a treatment, examination, surgical procedure, etc., so as to alleviate any anxiety the patient may feel. Promoting patient education can go a long way in improving patient satisfaction, improving patient compliance and reducing medical malpractice claims.

All the roles the medical assistant plays are of equal importance because the medical assistant establishes the atmosphere and creates the patient's image of the entire medical operation.

As the physician, you are the expert on the practice of medicine. Your medical assistant is the expert on your medical practice. This professional relationship is based on mutual respect and a shared concern for your patients' well being.

No matter what the specific job title - receptionist, bookkeeper, billing clerk, clinical assistant, technician, office manager, nurse - the medical assistant's expertise complements and extends your own. And just as your education and professional growth never stops, neither should your medical assistant's. That is why the Arkansas Society of Medical Assistant (ASMA) exists.

Table I. Certification Exam Areas

General	
	Medical terminology, anatomy and physiology
	Behavioral science: psychology, public relations, professional attitudes and growth
	Medical law and ethics
Administrative	
	Oral and written communication
	Bookkeeping
	Record-keeping and filing
	Office facilities and equipment
	Insurance
Clinical	
	Examination room techniques
	Sterilization procedures
	Medications, injections and pharmacology
	Storage and care of supplies and equipment
	Collection of specimens and laboratory procedures

* *President, Arkansas Society of Medical Assistants, Inc., Post Office Box 3472, Fayetteville, Arkansas 72702.*

What is ASMA?

The ASMA is a non-profit organization established for the professional medical assistant. The ASMA has dedicated itself to the continuing education and professional advancement of medical assistants. It is the goal of the ASMA to provide quality educational programs for your staff, both clerical and clinical. We recognize that health care professionals must continuously seek continuing education to more professionally assist in providing quality care to patients. Just as it is important for you as a physician to be constantly aware of changes in the medical profession, likewise, it is equally as important for your staff to be aware of changes in their aspect of the profession.

The ASMA provides at least three educational seminars per year for medical assistants. These programs are designed to help medical assistants stay abreast on current developments in the administration of health care. Continuing education units (CEU's) are often awarded for participation. The AMSA is recognized by the Arkansas Medical Society as the organization in the state providing educational opportunities for medical office staff members.

National Affiliation

The ASMA is an affiliate of the American Association of Medical Assistants (AAMA) which was founded in 1956. The AAMA is a national, state and local non-profit organization of medical assistants. The purpose of the AAMA is to promote the professional identity and stature of its members, and the medical assisting profession, through education and credentialing. On six occasions the American Medical Association has commended the AAMA for its commitment to the two associations' common goals of improved health-patient relations. Physicians serve as advisors on all levels of the AAMA offering counsel to the association. The AAMA offers superlative Guided Study programs that will allow medical assistants to learn at their own pace, on their own time. There is a variety of courses which carry CEU credit.

Professional Recognition - Credentialing

The AAMA Certifying Board offers an opportunity for medical assistants to make the move to professional status by becoming a Certified Medical Assistant (CMA). The CMA credential is awarded to those successfully completing the AAMA certification examination. The National Board of Medical Examiners serves as the AAMA's testing consultant. The revalidation program provides a mechanism to prove continued competency in the field.

The certification exam covers three major areas: general, administrative and clinical. These areas are detailed in Table I.

Training Programs

There are training programs for medical assistants, some offering two year associate degrees. There are two accredited schools in Arkansas: Arkansas Tech in Russellville and Capitol City Junior College in little Rock.

Collaborating jointly with AMA's Department of Allied Health Education and Accreditation, the AAMA Curriculum Review Board surveys medical assisting programs and makes accreditation recommendations to the Committee on Allied Health Education and Accreditation (CAHEA). Vigilance in maintaining curriculum standards ensures a steady flow of qualified medical assisting graduates, ready to take their place in the health care field.

Summary

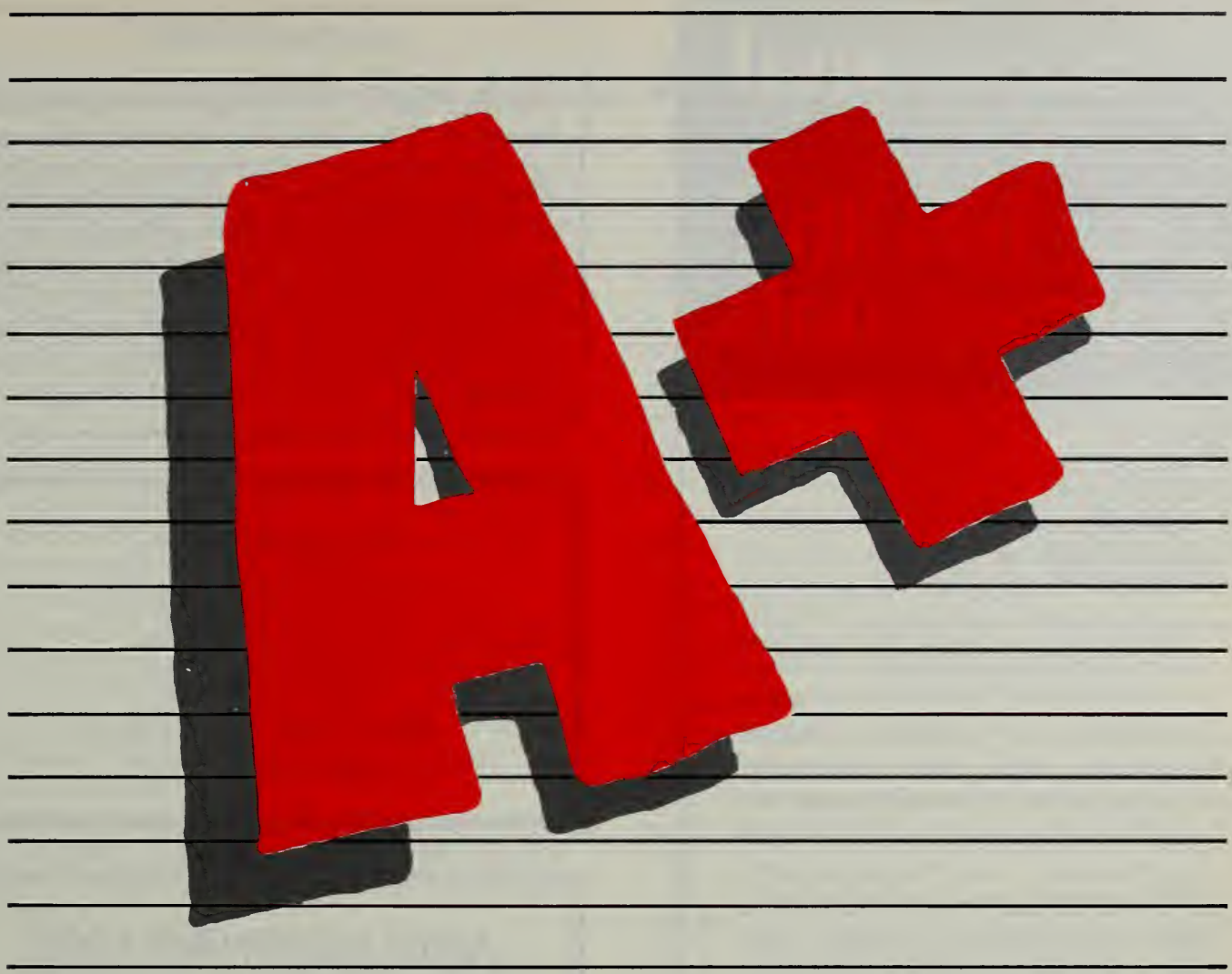
We encourage you to invest in your professional health care team by providing them the opportunity to improve their skills through educational programs presented by the ASMA. It is an investment which will pay dividends in the quality and professionalism of care for your patients.

May we also encourage you to invest in giving your staff the opportunity to become members of ASMA? We will be happy to discuss the organization with you of any member of your staff at anytime.

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Medical Students Host Annual Picnic

For the fifth time in six years, the Arkansas Medical Society Medical Student Section (AMS-MSS) pulled off a successful picnic for first and second year medical students. The event was held on August 25th at Maumelle State Park, just west of Little Rock. Sponsors of the event were the Arkansas Medical Society, First Commercial Bank of Little Rock and the Medical Protective Company.

According to the picnic committee chairperson, Cindy Gierach, who is also secretary/treasurer of the AMS-MSS, "a record number of students attended this year's picnic. In fact, approximately 400 students and guests braved the hot August weather to play volleyball, horseshoes, and enjoy some of the best fried catfish ever."

When asked about the purpose of the picnic, Ms. Gierach responded, "What we try to do each year is give the first-year students an opportunity to get to know their second-year colleagues, and to promote the Arkansas Medical Society and the AMS-MSS. The event is usually held during the first or second week of classes while everyone is still fresh."

One of the highlights of this year's picnic was the participation of Dr. James Weber, AMS president, and Dr. I. Dodd Wilson, Dean of the College of Medicine, as "celebrity chefs."

"We really appreciate Dr. Weber and Dr. Wilson for being such good sports. Everyone had an opportunity to meet them and get to know them on a personal basis. I think the students there enjoyed that," Ms. Gierach noted.

Dr. Weber and Dr. Wilson were given a reprieve from their duties by Ron McGaugh, AMS Medical Student Section President and David Wroten of the AMS staff.

According to Mr. Wroten, "The students really did an outstanding job of organizing this year's event. Special recognition should go to Cindy Gierach. She spent many hours planning, making all the arrangements and promoting the picnic. The evidence of her work was the largest crowd of medical students ever at an Arkansas Medical Society event."



David Wroten, AMS staff member, and Cindy Gierach, picnic committee chairperson, share a joke.

Ms. Gierach pointed out that several people helped make the event a success. These include Drs. Weber and Wilson, Everett Rowland (provided the food), Debbie Benton of First Commercial, Dan Stephens of The Medical Protective Company and students Ron McGaugh, Clay Ferguson, Lee Fleming and Don Steely.



Ron McGaugh, AMS-MSS President, shares his views with Dick Wheeler, M.D.



James Weber, M.D., AMS president and I. Dodd Wilson, M.D., Dean of the College of Medicine, were ready to serve - as celebrity chefs.

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OCTOBER 18-27

Allergy Abroad - Italy. Sponsored and presented by Washington University School of Medicine Continuing Medical Education. Padua, Florence, Rome, Italy. Twenty Category I credit hours. Fee: $495. For further information, contact: Loretta Giacoletto, Washington University School of Medicine, Office of Continuing Medical Education, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862.

OCTOBER 19-22

33rd ASIM Annual Meeting. Costs, Quality & Controls: Seeking the Right Balance. Sponsored and presented by ASIM. Includes ASIM business meetings, congressional visitation program for delegates, etc., organized for October 18. ASIM Board will meet both days. Category I credit available. For further information, contact: Barbara Lauter, ASIM, 1101 Vermont Avenue, NW, Suite 500, Washington, D.C. 20005-3457; (202) 289-1700.

OCTOBER 20-21

Cancer Conference IV. Presented by the faculty from M.D. Anderson Medical Center, Houston, TX. Sponsored by Greene County Medical Society (Missouri) and the American Cancer Society. Big Cedar Lodge, Table Rock, MO. Nine Category I credit hours. For further information, call Greene County Medical Society (Missouri) (417) 887-1017.

OCTOBER 27-28

Clinical Update in Geriatric Medicine. Presented and sponsored by the American Medical Association and the American Geriatrics Society. Drake Hotel, Chicago, IL. Hour-for-hour Category I credit available and 11 AAFP hours. Fee: AMA/AGS member, $275; non-member, $325; medical students & residents, $200. Further information, 1 (800) 621-8335.

NOVEMBER 3-4

Broad Scope of Pain Management Conference. Presented by Philipp M. Lippe, M.D.; Richard D. Black, M.D.; Gerald M. Aronoff, M.D.; and Russell K. Portenoy, M.D. Sponsored by the American Academy of Pain Medicine. Grand Kempinski Hotel, Dallas. Fourteen Category I credit hours. Fee: $200, AAPM member; $275, non-member. Further information: American Academy of Pain Medicine, 43 East Ohio, Suite 914, Chicago, IL 60611; (312) 645-0083.

NOVEMBER 5-8

83rd Annual Scientific Assembly of the Southern Medical Association. Presented by John A. Phillips, M.D.; Stylianos E. Antonarakis, M.D.; Robert M. Cook-Deegan, M.D. and John McLaughlin, Ph.D. Sponsored by the Southern Medical Association. Washington Convention Center, Washington, D.C. Category I credit available. Further information: Stuart Smith, SMA Media Relations, (816) 531-2100.

NOVEMBER 6-9

Primary Care Update: 74th Scientific Assembly of Interstate Postgraduate Medical Association. Sponsored by Interstate Postgraduate Medical Association. Town & Country Hotel, San Diego, CA. Twenty-four Category I and AAFP credit hours. Registration fee: $200, advance; $225, on-site, $35, residents and interns; $50, allied health professionals. Further information, Interstate Post Graduate Medical Education, Post Office Box 5474, Madison, WI 53705; (608) 257-1401.

NOVEMBER 14-17

1989 National Institute on Health Care Leadership and Management. Presented and sponsored by the American College of Physician Executives. The Westin La Paloma, Tucson, AZ. Hour-for-hour Category I credit available. Fees vary from $880-$220 for members; $960-240 for non-members. Further information: American College of Physician Executives, 4830 West Kennedy Blvd., Suite 648, Tampa, FL 33609-2517.

NOVEMBER 14-17

1989 National Forum on Health Care Quality Improvement. Sponsored by the Joint Commission on Accreditation of Health Organizations. Hyatt Regency O'Hare, Chicago, IL. Twelve Category I and CEU hours offered. Fee: $495. Further information: JCAHO, 875 North Michigan Avenue, Chicago, IL 60611; (312) 649-8023.

NOVEMBER 19-21

Fourth National Forum on AIDS and Hepatitis B. Sponsored by the American Medical Association. Washington, D.C. For further information, contact the National

Foundation of Infectious Diseases, 4733 Bethesda Avenue, Suite 750, Bethesda, MD 20814; (301) 656-0003.

NOVEMBER 26 - DECEMBER 1

75th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Presented and sponsored by RSNA. McCormick Place, Chicago, IL. For further information, contact Carolyn Mills, RSNA at (312) 558-1770.

NOVEMBER 30 - DECEMBER 1

Improving Quality in Long Term Care. Presented by the Joint Commission on Accreditation of Healthcare Organizations and the American Geriatrics Society. Westin Hotel, Chicago, IL. Nine Category I credit hours; 11.7 CEUs. Fee: $390. Further information: JCAHO, Department of Education Programs, 875 North Michigan Avenue, Chicago, IL 60611; (312) 649-8023.

DECEMBER 8-9

Physicians, Family and Addictions. Presented and sponsored by the Medical Society of Virginia Health and Effectiveness Program. Royce Hotel, Williamsburg, VA. Further information: Jeanne N. Douglas, 1 (804) 353-2721.

DECEMBER 15-17

Pediatric Update. Presented by Betsy Busch, M.D.; Dennis L. Christie, M.D.; Gerald W. Fischer, M.D.; Gerald B. Merenstein, M.D.; Richard J. Whitley, M.D.; and Errol R. Alden, M.D. Sponsored by the American Academy of Pediatrics. Williamsburg Lodge and Conference Center, Williamsburg, VA. Sixteen Category I credit hours. Fees: AAP Resident or Candidate Fellow or Allied Health Professional, $220; AAP Fellow, $300; Nonmember, $365. Further information: 1 (800) 433-9016.

FEBRUARY 1990

31st Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. Sponsored and presented by the Johns Hopkins University School of Medicine. February - April 1990: Home Study Course A is provided for reading and microscopic study in own laboratory in preparation for Course B. April 23 - May 4: In-Residence Course B is a concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore, MD. 152 Category I credit hours. Registration must be complete before Jan. 1, 1990. Further information: John K. Frost, M.D., or Ms. Betty Ann Remley, 111 Pathology Bldg., Johns Hopkins, Baltimore, MD 21205; (301) 955-8594.

KEEPING UP

Cholesterol: Current Concepts for Physicians

Self-Study Course for Physicians. Sponsored by the National Heart, Lung and Blood Institute. A national cholesterol education program is available through the Arkansas Medical Society office in which a physician studies at home. Two Category I credit hours. Further information: David Wroten, Arkansas Medical Society, Post Office Box 5776, Little Rock, AR 72215; (501) 224-8967.

Esophageal Reflux and Dyspepsia

October 5, 12:00 noon. Presented by Charles Paris, M.D. Sponsored by AHEC Fort Smith. Century Dining Room, Sparks Regional Medical Center.

Pediatric Literature Review

October 11, 12:30 p.m. Presented by Richard Acklin, M.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

HIV Testing & Counseling

October 12, 12:30 p.m. Presented by Jim Acklin, M.D. and Russell Williams. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Polycythemia & Anemia

October 17, 12:00 noon. Presented by Robert Arrington, M.D. Sponsored by AHEC Fort Smith. Century Dining Room, Sparks Regional Medical Center.

Drugs and Renal Function (NSAI)

October 18, 12:00 noon. Presented by Andrew Whelton, M.D. Sponsored by AHEC Fort Smith. Century Dining Room, Sparks Regional Medical Center.

Acute Care of The Critically Ill Child

October 19 & 20, 7:45 a.m. - 4:45 p.m. Presented by Michele Moss, M.D.; Rhonda Dick, M.D., and Debra Fiser, M.D. Sponsored by Arkansas Children's Hospital. Sturgis Auditorium. Fifteen Category I credit hours. Fee: $200. Further information: Blanche Moore, Arkansas Children's Hospital, 800 Marshall Street, Little Rock, AR 72202, 370-1481.

Avoiding Problems with the PRO

October 21, 7:30 - 10:00 a.m. Presented by Donald Baker, M.D. Sponsored by UAMS AHEC Northwest. Washington Regional Medical Center, Baker Conference Center, 1125 N. College, Fayetteville. Two Category I credit hours. Fee: $10, includes breakfast.

Primary Care Update

October 26 & 27, times to be announced. Presented and sponsored by Baptist Medical Center Medical Education Department. Baptist Medical Center, J.A., Conference Center. Further information: Baptist Medical Center, Medical Education at (501) 227-2672.

Failure to Thrive: A Team Approach

October 27, 8:00 a.m. - 3:15 p.m. Presented by Patrick H. Casey, M.D., Mary DeBlock, R.N.P. and other UAMS/ Arkansas Children's Hospital staff. Sponsored by Arkansas Children's Hospital. Arkansas Children's Hospital, Sturgis Building Auditorium. Five Category I credit hours for physicians; 5 contact hours for social workers; credit pending for nurses and dietitians. Registration fee: $40. Further information: Blanche Moore, Arkansas Children's Hospital, 800 Marshall Street, Little Rock, AR 72202, 370-1481.

Immunization Update

November 1, 12:30 p.m. Presented by Charles Floyd, M.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Infectious Disease Update

November 6-11. Presented by Richard F. Jacobs, M.D., Terry Yamauchi, M.D., A. Wesley Burks, M.D. Sponsored by Arkansas Children's Hospital. Camino Real Hotel, Ixtapa, Mexico. Registration fee: $250. Airfare: $150. Twelve hours Category I credit. Further information, Blanche Moore, Continuing Education Director, Arkansas Children's Hospital, 800 Marshall, Little Rock, AR 72202; (501) 370-1481.

Reality Therapy & Families

November 9, 12:30 p.m. Presented by Bruce Allen, L.C.S.W. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

AIDS in Arkansas

November 11, 7:30 a.m. - 10:00 a.m. Presented by Linda Markland, M.D. Sponsored by UAMS AHEC - Northwest. Washington Regional Medical Center, Baker Conference Center, Fayetteville. Two Category I credit hours. Registration fee: $10, includes breakfast.

Pediatrics in Family Practice

November 17, 9:00 a.m. - 4:30 p.m. Presented by Robert Glenn, M.D., and Arkansas Children's Hospital Staff. Sponsored by Arkansas Children's Hospital. Arkansas Children's Hospital, Little Rock. Six Category I credit hours. Registration fee: $80. For further information, contact Blanche Moore, Arkansas Children's Hospital, 800 Marshall, Little Rock, AR 72202; (501) 370-1481.

Septic Shock

November 28, 12:00 noon. Presented by Russell Steele, M.D. Sponsored by AHEC Fort Smith. Century Dining Room, Sparks Regional Medical Center.

Pediatric Cardiology

November 29, 12:00 noon. Presented by Arkansas Children's Hospital cardiologist. Sponsored by AHEC Fort Smith. Century Dining Room, Sparks Regional Medical Center.

Acute MI

November 30, 12:00 noon. Sponsored by AHEC Fort Smith. Century Dining Room, Sparks Regional Medical Center.

Recurrent Pneumonia in Children

December 6, 12:30 p.m. Presented by Louay Nassri, M.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Acute Care of the Critically Ill Child

December 7 - 9, times to be announced. This course is a more intensive version of the October offering. Sponsored by Arkansas Children's Hospital. Further information: Blanche Moore, Arkansas Children's Hospital, 800 Marshall Street, Little Rock, AR 72202, 370-1481.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Tuesday or Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, altemating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Building Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, Sturgis Building, Room 121
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Second Floor Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, Sturgis Building, Rooms S120-121
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

AIDS Conference, second Friday, 12:00 noon, Location to be announced. Sandwich buffet.
CARTI Cancer Conference, first Wednesday, 12:00 noon, CARTI Auditorium. A meal is provided.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell Room. A meal is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. A meal is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Arkla Room. Refreshments are provided.
Internal Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. A meal is provided.
Pediatric Conference, first Tuesday, 12:30 p.m., LaHarpe de Paul Room. A meal is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, fourth Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS Education Building, Room G137, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:30 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159

Surgery Fundamental Sciences Conference, first Tuesday, 6:00 p.m., UAMS Chancellor's Area, Conference Room B-2
Surgery Grand Rounds, one Saturday per month, 8:00 a.m., UAMS Education Building, Room G/141A, 1.5 credit hours
Surgery Morbidity and Mortality Conference, Wednesdays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Resident Case Conference, Mondays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Review Conference, Mondays, 6:00 p.m., UAMS Education Building, Room G/141A
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Conference (Pediatric), once monthly, 5:00 p.m., Arkansas Children's Hospital, Sturgis Building, Clinic 2
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), altemating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Tuesdays, 5:00 p.m., UAMS Education Building, Room G/131A&B

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Intemal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bemard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village
Chest Conference, fourth Tuesday, 12:00 noon, St. Bemard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bemard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bemard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bemard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bemard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.

Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

NEW MEMBERS

ASHLEY COUNTY

Holt, Terry L., Family Practice, Crossett. Born June 14, 1955, Fort Smith. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1977. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1986. Internship/residency, Sparks Regional Medical Center. Board eligible. Member, AAFP, Sebastian County Medical Society.

BAXTER COUNTY

Marx, Douglas W., Ophthalmology, Mountain Home. Born June 4, 1950, Biloxi, MS. Pre-medical education, McNeese State University, Lake Charles, LA, 1976. Medical education, Louisiana State University Medical School, New Orleans, 1980. Internship, Naval Hospital, San Diego, CA. Residency, Naval Hospital, Oakland, CA. Military record, U. S. Army, 2 years; U. S. Navy, 7+ years. Board certified, Ophthalmology. Member, AAP, AMA.

Wells, Gary B., Radiation Oncology, Mountain Home. Born December 26, 1956, Augusta, GA. Pre-medical education, University of Georgia, Athens, B.S., 1981. Medical education, Medical College of Georgia, Augusta, 1985. Internship/residency, University of Washington, Seattle. Board eligible. Member, ACR, American Society for Therapeutic Radiology and Oncology.

BOONE COUNTY

Bennett, Chris N., Radiology, Harrison. Born September 9, 1955, Helena. Pre-medical education, University of Arkansas, Fayetteville, B.A., 1979. Medical education, University of Arkansas for Medical Sciences, 1983. Internship/residency, UAMS. Board certified, Radiology.

CLARK COUNTY

Hagood, Jr., Noland H., Family practice, Arkadelphia. Born February 1, 1960, Crossett. Medical education, University of Arkansas, B.A., 1982. Medical education, University of Arkansas for Medical Sciences, 1986. Internship/residency, AHEC - Pine Bluff. Board eligible. Member, AAFP.

Studdard, Daniel M., Family Practice, Gurdon. Born February 6, 1955, Pine Bluff. Pre-medical education, Ouachita Baptist University, B.S., 1978. Medical education, College of Osteopathic Medicine and Surgery, Oklahoma City, 1986. Internship, Oklahoma Osteopathic Hospital, Tulsa. Residency, AHEC, Pine Bluff. Board eligible. Member, ACGPOMS, AAFP, AMA, AOA.

CRAIGHEAD COUNTY

Souther, Susan J., Cardiology, Jonesboro. Born July 29, 1956, Maryville, TN. Pre-medical education, University of Tennessee, Knoxville, B.A., 1977. Medical education, University of Tennessee, Memphis, 1983. Internship/residency, University of Tennessee, Memphis. Board eligible. Member, ACC, ACP.

FAULKNER COUNTY

Stancil, Vicki L., Family Practice, Conway. Born September 21, 1957, Little Rock. Pre-medical education, University of Arkansas, Little Rock, B.S., B.A., 1980. Medical education, University of Arkansas for Medical Sciences, 1984. Internship/residency, University of Texas Health Science Center, San Antonio. Board certified, Family Practice. Member, AAFP, Montana Medical Society, MAFP.

JEFFERSON COUNTY

Anderson, Mark D., Cardiology, Pine Bluff. Born November 22, Spokane, WA. Pre-medical education, Drury College, Springfield, MO, B.A., 1978. Medical education, Tulane University, New Orleans, 1983. Internship/residency, University of Missouri, Columbia. Board eligible. Member, ACC.

Atkinson, Robbie R., Oral Surgery, Pine Bluff. Born

July 29, 1946, Star City, AR. Pre-medical education, Arkansas Agricultural and Mechanical College, 1967. Medical education, University of Texas Medical School, San Antonio, 1979. Internship/residency, Bexar County Hospital District, TX. Practice experience, 1976-78, San Antonio; 1979 to present, Pine Bluff. Member, American Society of Oral Surgery.

Bennett, Keith G., General Surgery, Pine Bluff. Born February 3, 1958, Jonesboro. Pre-medical education, Arkansas State University, B.S., 1980. Medical education, University of Arkansas for Medical Sciences, 1984. Internship/residency, University of Oklahoma. Board eligible. Member, Oklahoma Medical Society.

Busby, John R. "Bo", General Surgery/Thoracic Cardiovascular, Pine Bluff. Born December 30, 1954, Little Rock. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1978. Medical education, University of Arkansas for Medical Sciences, 1982. Internship/residency/fellowship, Ochsner Foundation, New Orleans. Board certified. Member, AMA ACS,SMA, Ochsner Surgical Society.

Estes, David S., Internal Medicine, Pine Bluff. Born February 21, 1959, Stuttgart. Pre-medical education, University of Arkansas, B.S. 1981. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, University of Oklahoma, Tulsa. Practice experience, 1 year, Stuttgart.

LONOKE COUNTY

Elam, Garrett J., General Practice, England. Born October 20, 1955, Kirksville, MO. Pre-medical education, Northeast Missouri State University, Kirksville, B.S., 1978. Medical education, Kirksville College of Osteopathic Medicine, 1983. Internship, Normandy Hospital, St. Louis. Practice experience, 5 years, St. Louis. Member, American Osteopathic Association.

POPE COUNTY

Hollabaugh, Denise T., General Practice, Hector. Born December 24, 1946, Billings, MT. Pre-medical education, Northeast Louisiana University, B.S. 1971. Medical education, Louisiana State University Medical Center, Shreveport, 1986. Internship, E. A. Conway Memorial Hospital, Monroe, LA. Military record, U. S. Marine Corps, 1965-68. Practice experience, 1 year, Monroe, LA.

Speed, Darrell L., Radiation Oncology, Russellville. Born November 3, 1942, Oklahoma City. Pre-medical education, University of Oklahoma, B.S. 1964. Medical education, University of Oklahoma, Oklahoma City, 1970. Internship, St. Elizabeth Hospital, Dayton, OH. Residency, Oklahoma Health Sciences Center, Oklahoma City. Military record, U. S. Navy Reserve, 1971-74. Practice experience, 2 years, Oklahoma City; 10 years, Ada, OK. Member, American Society of Therapeutic Radiology and Oncology.

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Bowles, Mark H., Cardiology, Little Rock. Born July 6, 1948, Dermott, AR. Pre-medical education, Ouachita Baptist University, Arkadelphia, B.S., B.A. Medical education, University of Arkansas for Medical Sciences, 1975. Internship/residency, Little Rock V. A. Medical Center; UAMS V.A. Medical Center; St. Luke's Hospital, Kansas City, MO. Practice experience, 1980-85, Bentonville; 1987-89, Wichita, KS. Board certified, Internal Medicine, Gastroenterology, Cardiology.

Byrum, Jerry D., Pediatrics, Little Rock. Born December 14, 1958, Little Rock. Pre-medical education, Ouachita Baptist University, B.S., 1981. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, UAMS. Practice experience, 1988-89, Jacksonville. Board eligible.

Gillespie, J. Barry, Internal Medicine and Pediatrics, Little Rock. Born November 15, 1953, Jackson, MS. Pre-medical education, Vanderbilt University, Nashville, TN, B.A., 1975. Medical education, University of Mississippi Medical School, Jackson, 1985. Internship/residency, UAMS. Board eligible.

Neal, David F., Physical Medicine and Rehabilitation, Little Rock. Born March 22, 1948, TN. Pre-medical education, Duke University, Durham, NC, B.A., 1970. Medical education, University of Tennessee, Memphis, 1978. Internship, City of Memphis Hospitals. Residency, Medical Center Hospital, San Antonio, TX; Jackson-Madison County Hospital, Jackson, TN; Parkland Memorial Hospital, Dallas, TX. Board certified, Family Practice; eligible, Physical Medicine and Rehabilitation.

Seibert, Robert W., Otolaryngology, Little Rock. Born April 21, 1943, Mexico, MO. Pre-medical education, Southwestern College, Memphis, B.A., 1965. Medical education, University of Memphis. Internship, City of Memphis Hospital. Residency, University of Tennessee, Memphis; V. A. Hospital, Memphis; University of Iowa, Iowa City. Board certified, Otolaryngology.

Suen, James Y., Otolaryngology, Little Rock. Born October 9, 1940, Dermott, AR. Pre-medical education, University of Texas, Austin, B.A., 1966. Medical education, University of Arkansas for Medical Sciences, 1966. Internship/residency, San Francisco General Hospital; UAMS; M. D. Anderson Hospital & Tumor Institute, Houston. Practice experience, 1974 to present, M. D. Anderson Hospital & Tumor Institute, Houston. Board certified, Otolaryngology.

RANDOLPH COUNTY

Baltz, Mark A., Family Practice, Pocahontas. Born June 11, 1957, Pocahontas. Pre-medical education, Arkansas State University, B.S., 1979. Medical education, University of Arkansas for Medical Sciences, 1983. Internship/residency, UAMS - AHEC Northeast. Practice experience, 3 years, Pocahontas. Board certified, Family Practice.

SEBASTIAN COUNTY

Ashcraft, Cynthia K., Pediatrics, Fort Smith. Born October 22, 1958, Pine Bluff. Pre-medical education, Ouachita Baptist University, B.S., 1980. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, Arkansas Children's Hospital. Member, American Academy of Pediatrics.

UNION COUNTY

Barenberg, Robert L., Nephrology, El Dorado. Born November 2, 1934, Boston, MA. Pre-medical education, Massachusetts Institute of Technology, Cambridge, B.S., 1956. Medical education, Albany Medical College of Union University, Albany, NY, 1960. Internship, University of Minnesota Hospital, Minneapolis. Residency, Cleveland Metropolitan General Hospital, Cleveland, OH. Fellowship, Cleveland Clinic; University of New Mexico School of Medicine, Albuquerque. Practice experience, 10 years, New Mexico; 2 years, Florida; 2 years, Pennsylvania; 1979-present, Wichita Falls, TX.

WASHINGTON COUNTY

Hendrycy, Paul R., Pathology, Fayetteville. Born October 18, 1952, Summit, NJ. Pre-medical education, Emory University, B.A., 1973. Medical education, Emory University, 1977. Internship, University of California, San Diego Hospitals. Residency, University of Southern California, L.A. County Medical Center. Fellowship, University of Texas Medical Branch, Galveston. Practice experience, 1982-88, Corpus Christi, TX; 1988- 89, Fayetteville. Board certified, pathology. Member, American Society for Microbiology, College of American Pathology.

McBee, Sara E., Oseteopathy, Fayetteville. Born August 20, 1943, Maquokela, IO. Pre-medical education, University of Arkansas, B.A., 1981. Medical education, Oklahoma College of Osteopathic Medicine, 1986. Internship, Oklahoma Osteopathic Hospital, Tulsa. Residency, UAMS - AHEC Northwest, Fayetteville.

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Yeager, Angy M.

In Memoriam

TED H. PYE, M.D.

Ted H. Pye, M.D, a radiologist practicing in Nashville, Arkansas, died September 12, 1989. He was 56.

Dr. Pye was an active member of the Arkansas Medical Society and the American Medical Association as well as the Texas Medical Association. He was also a member of the American College of Radiology.

Dr. Pye is survived by his wife, Louise Winters Pye of Nashville; two sons, Theo H. Pye Jr. and Robert Jerome Pye of Houston; three daughters, Jessie Lynn Pye of West Germany, Felicia Paige Bentley of Houston and Traci Renee Franks of Little Rock; other survivors include a brother, Allen E. Pye of Tyler, Texas.

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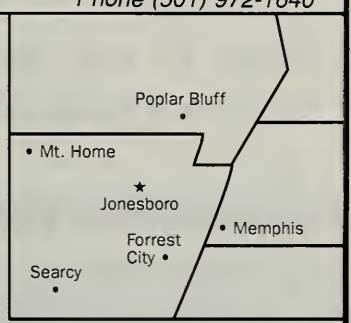
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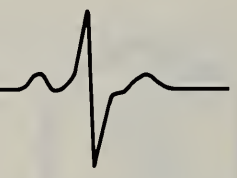
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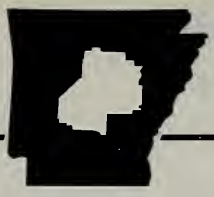
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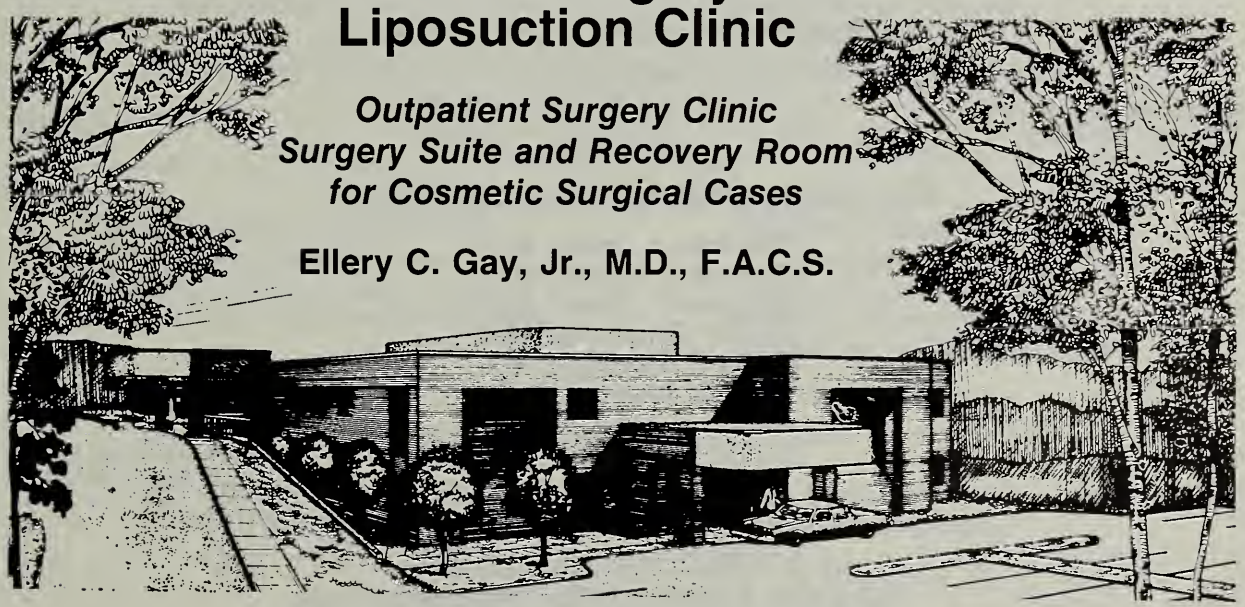
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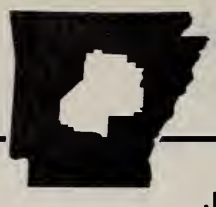
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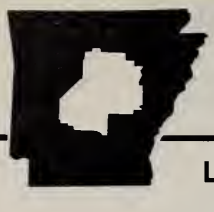
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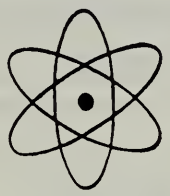
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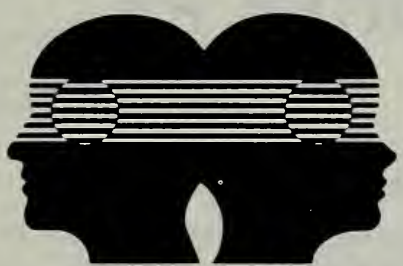
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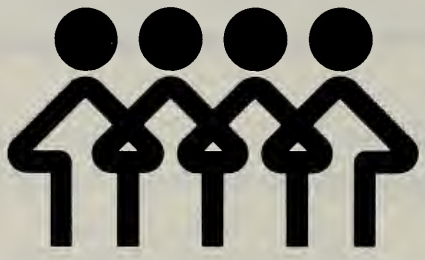
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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects*.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions*.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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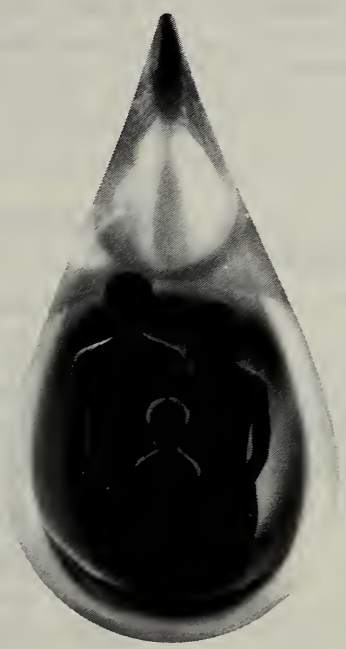
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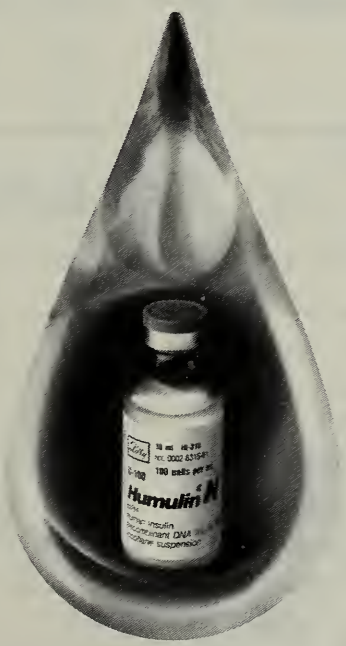
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On Our Cover: The artist of this work is Chris Huff, a high school student from Fouke, Arkansas. It is included in the "1989 Young Arkansas Artists" exhibition scheduled to appear at the Arkansas Arts Center in April and May, 1990.

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Update: October 1989 Guidelines for Nutrition Support in AIDS

Task Force on Nutrition in AIDS*

The nutritional status of people with AIDS is challenged throughout the progression of the illness by the manifestation of symptoms such as malabsorption, diarrhea, candidiasis, and fever. As yet, there is no widely accepted method for nutritional management of AIDS. Therefore, a Task Force on Nutrition Support in AIDS was formed to develop practical recommendations for those involved in the management of this patient population. The "Guidelines for Nutrition Support in AIDS" are aimed at improving nutritional status, alleviating symptoms, and enhancing quality of life at each stage of the disease. The Task Force concluded that optimizing the nutritional status of people with AIDS, through aggressive nutritional therapy, is essential in overall medical management; nutrition intervention and education is indicated as early in the disease progression as HIV diagnosis; thorough nutritional assessment and regular monitoring is advocated; and enteral feedings should be considered the first line of nutrition support therapy.

Introduction

The course of acquired immune deficiency syndrome (AIDS) is often complicated by profound weight loss, cachexia, multiple nutrient deficiencies, and particularly, protein calorie malnutrition (PCM).[1,2] Throughout the progression of the disease, the nutritional status of people with AIDS is challenged by the manifestation of symptoms such as malabsorption, diarrhea, oral/esophageal problems, nausea/vomiting, and infection. The multifactorial nature of AIDS produces a different combination of these symptoms in each individual. As with any chronic disease, the severe malnutrition that frequently accompanies AIDS could decrease longevity and increase morbidity.[3] In addition, the quality of life for people with AIDS might be severely compromised when their primary disease is accompanied by major nutritional complications.[4]

Studies of individuals with PCM and other nutrient deficiencies have shown a depression in cellular immunity with abnormal T cell and macrophage function.[5] Such changes could theoretically compound the immunodeficiency in people with AIDS, rendering them more susceptible to infection or exacerbating the severity of existing infections. Ensuring optimal nutritional status should generally improve quality of life, and might prevent additional impairment of the immune system.[2]

At present there are very few studies on the nutritional status of people with AIDS. In an attempt to gain some control over their health, people with AIDS are highly susceptible to health claims by faddists and so-called "alternative therapists." Many unproven remedies, such as macrobiotic diets and vitamin megadosing may actually worsen nutritional status.[6] The etiology of the cachexia of AIDS, the incidence of macro- and micronutrient deficiencies, and the effects of various nutritional therapies are largely unknown.

Faced with this lack of knowledge, the potentially harmful nutritional therapies being used by people with AIDS, and the need for an integrated approach to the nutritional management of AIDS, a national Task Force on

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Nutrition Support in AIDS* convened to develop practical recommendations.

This report presents the recommendations formulated by the Task Force at a meeting in June, 1988. In making its recommendations, the Task Force set primary goals for good nutritional management as follows:

* preserve lean body mass
* provide adequate levels of all nutrients
* minimize symptoms of malabsorption

General Recommendations

Nutrition Education

People with AIDS represent all segments of society, with varying amounts of nutritional knowledge. The nature of AIDS results in a wide spectrum of severity and length of the illness from its complications. Thus, there is an urgent need for nutritional counseling, beginning with the diagnosis of a positive HIV serology and extending throughout the course of the disease. Nutritional counseling must become an integral part of the management of AIDS, and should include:

* An understanding of the value of a good diet to protect against exacerbation of nutritional complications
* Knowledge about nutrition support options

Nutrition Assessment

As part of the patient's medical and physical examination, include a careful nutritional assessment, and arrange routine follow-up to monitor changes. Consult with a nutrition support team or a registered dietitian to insure that the assessment includes:

* diet history (past and present)
* calculation of nutrient intake
* anthropometric measurements such as weight, height, skinfold thickness, and midarm circumference (to measure somatic protein stores) [see Appendix B.]
* laboratory tests for anemia (blood count), long-term PCM (serum albumin)
* functional measurements of muscle power (e.g. hand grip strength) and short-term visceral protein deficits (serum retinol-binding protein and prealbumin), when PCM is suspected.

Nutrient Requirements

Of primary concern is adequate calorie consumption. Caloric requirements can be calculated using a standard method such as the Harris-Benedict equation.[7,8] (See Appendix A.) Since weight loss often accompanies a systemic illness, food intake may not be sufficient to meet caloric requirements. Set a realistic goal to minimize further weight loss. Insure an adequate dietary intake throughout the duration of the illness, and utilize remission periods to optimize nutritional repletion.

High fat foods provide a good source of calories, but may need to be restricted in the presence of malabsorption or diarrhea.

Nitrogen requirements during stressed states are increased, requiring dietary protein of optimal quality and quantity.

Advise individuals with AIDS consuming an inadequate oral diet to take a daily multivitamin/mineral supplement which supplies 100% of the Recommended Dietary Allowances (RDA) for each nutrient. When antifolate drugs are used to treat opportunistic infections, it may be necessary to provide folic acid supplements during treatment.[10]

Nutrition Support

When dietary needs of any medically compromised individual cannot be met by a regular, well-balanced diet, introduce nutrition support. Support can include blended food products, commercial formulas, and intravenous solutions.

To select the most appropriate nutrition support formula, consider gastrointestinal function, length of time required for nutritional repletion, cost, patient acceptance, and feasibility of at-home use. Immediate follow-up to evaluate individuals' acceptance of, and tolerance of the selected formula is essential.

When functioning, the gastrointestinal tract is the preferred route of nutrient delivery to maintain the structural and functional integrity of the GI mucosa.[11] Intestinal mucosa can become significantly atrophied if the patient takes nothing enterally for an extended period of time.[12]

Diarrhea is often considered an inevitable consequence of tube feedings, however it is more often the result of underlying problems. Because most feedings contain little or no fiber, a tube-fed patient cannot be expected to have a formed stool. Malnutrition results in a reduction of absorptive surface area, but can be reversed with nutritional repletion. Hypoalbuminemia, antibiotic therapy, bacterial contamination of a formula, improper rate and strength of administration, and formula temperature are also potential causes of diarrhea. Rule out all other possible causes of diarrhea before discontinuing the feeding.[13,14]

Enteral nutrition formulas are effective as adjuncts to regular oral intake, or as the sole source of nutrition. Enteral products include nutritionally complete elemental or polymeric formulas, and modular formulas, and are delivered via the alimentary tract.

Elemental formulas consist of predigested nutrients (i.e., free amino acids, essential fatty acids and oligosaccharides), require minimal digestion and thus promote maximal absorption. These formulas are usually less than 5% fat, low-residue and lactose-free - important considerations for many

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people with AIDS who suffer from diarrhea and/or malabsorption.

Polymeric formulas contain complex carbohydrates and are higher in fat content than elemental diets. The most commonly used polymeric formulas are lactose-free and have variable caloric densities and osmolalities.

Modular, or single nutrient formulas, are used to modify other enteral formulas, and are tailored for specific nutrient needs.

Intravenous solutions include varying amounts of dextrose, fat amino acids, electrolytes, vitamins and minerals.

Nutrient Administration

Enteral: When possible, use a formula containing protein, carbohydrate, and fat. When these formulas cannot be tolerated, use partially digested or elemental formulas. Provide enteral formulas in the following order:

* Orally: Taste can be improved with flavor packets or juices.
* Transnasal feeding tubes: Continuous infusion of nutrients with nasogastric, nasoduodenal, or nasojejunal feeding tubes are preferred to provide all or most of the individual's nutrition. The nasogastric route allows for intermittent or nocturnal use, (for ambulatory individuals).
* Surgical placed feeding tubes: Percutaneous endoscopic gastrostomy (PEG) and small bore feeding tubes placed into the small intestine are appropriate when a long-term feeding is indicated, or when oral/esophageal complications preclude the nasal route.

Parenteral: Parenteral nutrition should be used as the sole source of nutrition only when enteral feeding is not feasible. During the terminal stages of the disease, include family or friends, the primary care giver, and the patient's prior wishes in the decision on whether to feed parenterally.

* Peripheral Parenteral Nutrition (PPN): Delivered via a peripheral vein, it is appropriate when short-term (7-10 days), in hospital preservation of lean body mass is needed.
* Central Parenteral Nutrition (CPN): Delivered via a central vein, this route should be reserved for patients with totally nonfunctional gastrointestinal tracts. It can also be used concomitantly with enteral feeding to meet extraordinary caloric requirements.

Asymptomatic People Who are HIV+

Rationale

Significant weight loss is a common occurrence in the progression of AIDS.[15] Early nutritional assessment and institution of corrective measures may slow weight loss and avoid nutritional complications seen in later stages of the disease.

Nutritional objectives for individuals diagnosed as HIV positive are to obtain baseline nutritional status; sustain lean body mass, preserve nutrient deficiencies, and optimize nutritional stores.

Recommendations

Perform a routine blood count with differential upon HIV identification. If indicated, do a complete work-up for anemia, an early sign of progressive HIV infection,[16] and conduct an investigation for specific micronutrient deficiencies, such as selenium and zinc[17,18] which may result from malabsorption, severe overt wasting, or bizarre food intake.

Provide nutrition counseling at diagnosis to stress the value of proper diet throughout the disease progression. Encourage a balanced diet incorporating individualized food preferences, including a variety of foods, and containing an adequate intake of protein and calories to preserve lean body mass. Outline the nutritional options available to supplement a regular diet. Since diets that do not ensure an adequate and balanced intake of nutrients may further compromise immune status, discourage nontraditional dietary practices (in a nonjudgemental manner), such as macrobiotic and fad diets, herbal powders, and vitamin megadosing.

Anorexia

Rationale

Anorexia is a loss or change in appetite with a relative decrease in food intake that, left untreated, will result in a decline in body weight, fat, and cell mass.[19] It may occur as a direct consequence of AIDS manifestations or in response to drug therapy. Oral and esophageal ulcers, dysphagia, fever, malaise, dysgeusia, and specific nutritional deficiencies may depress appetite and exacerbate anoretic behavior.[20] Psychological factors, such as anxiety and depression, may also contribute to anorexia.[20] Eating is often self-limited by early satiety, as well as fear of pain or diarrhea. Therefore, early recognition of anorexia associated with AIDS and nutrition intervention is essential.

Recommendations

Monitor body weight and utilize diet histories and calorie counts to assess changes in the selection and quantity of foods consumed.

Individualized meal plans will stimulate intake, therefore cater to personal tastes. Suggest small, frequent feedings which can be less overwhelming than large meals. Avoid increasing food quantity by providing nutrient dense food items. If an aversion to particular foods exists, (e.g. meat), offer an acceptable nutrient replacement.

Offer favorite foods in a pleasant atmosphere and encourage the presence of family members or companions during meals.

When nutrient intake is suboptimal, or significant weight loss is recorded, a more aggressive approach is necessary. In this instance, provide calorically dense, enteral formulas to supplement or replace the regular oral diet.

When oral nutrient support does not provide adequate protein and calories, initiate a tube feeding. When the gastrointestinal tract is functional, parenteral nutrition is not an appropriate option.

Disorders of the Oral/Esophageal Cavity

Rationale

Oral and esophageal complications are common in people with AIDS and may interfere with the ability to eat. In one study, 94% of people with AIDS had oral candidiasis,[21] which produces pain and limits salivation. Pharyngeal or esophageal lesions of Kaposi's sarcoma may cause obstruction, while herpetic or other ulcers can cause difficulty in swallowing, and aspiration may result. Dysgeusia may be cause by nutrient deficiencies, drugs, candidiasis, excessive mucus production (postnasal drip), or dry mouth.

Most of these lesions are responsive to therapy, and short-term dietary modification may enable the person with AIDS to maintain oral food intake. For individuals with extensive or chronic lesions, enteral or parenteral nutrition may be indicated.

Recommendations

Encourage maximum oral intake through diet modification (see Table I). Small amounts of fluids given with meals can improve the ability to chew and swallow. Foods served at cool temperatures are generally more soothing. Maintenance of good oral and dental hygiene also contributes to optimal oral intake.

When taste sensation is altered, make temperature and texture adjustments to stimulate sensory feedback, salivation, and appetite. Saliva production can be stimulated with liquids at mealtime, sour candy, or gum. For individuals with poor swallowing coordination, thicken liquids with ingredients such as powdered milk, mashed potato, corn starch, or oatmeal. To avoid aspiration, the ideal consistency for foods is a semi-solid state. Food or food combinations should be of uniform consistency and easily form and maintain a cohesive bolus in the mouth and pharynx; therefore, eliminate foods such as stew. Advise against foods that stick to the palate (e.g. peanut butter, white bread) and slippery foods (e.g., bologna, macaroni, jello). If aspiration is a potential problem, healthcare providers should consult a specialist (E.N.T., speech pathologist) trained in this area.

Table I. Oral Manifestations Feeding By Mouth

	Acidic Foods/Bev	Temperature	Texture/ Consistency	Seasonings
Mouth/Pain Sores	Avoid • citrus • pineapple	Avoid extremes	Non-abrasive, easy to swallow foods	Spices & salt may not be tolerated
Dulled Taste Sensation	Provide acids to breakdown mucus	Provide extremes to stimulate appetite	Variety of textures	Provide as tolerated to stimulate appetite
Partial Esophageal Obstruction	Avoid if open lesions	N/A	Adjust for mechanical soft or liquid as tolerated	Avoid "hot" spices if open lesions
Swallowing Dysfunction	N/A	Provide extremes (Hot or Cold) to stimulate sensation	• Avoid thin liquids • Avoid true solids • Provide food or food combinations resulting in cohesive bolus • Avoid sticky foods • Avoid slippery foods	Provide to stimulate mouth sensation

If mouth lesions make oral intake difficult and are expected to continue for longer than three days, consider an intermittent or continuous enteral feeding to meet caloric requirements. If no other gastrointestinal symptoms exist, any nutritionally balanced formula is adequate. When esophageal ulcers preclude the use of a nasogastric tube, consider short-term (7-10 days) peripheral parenteral nutrition for hospitalized patients. For prolonged situations (longer than 10 days), or hor home patients, initiate enteral nutrition support via an alternate tube feeding route, such as a PEG.

Nausea and Vomiting

Rationale

Protracted nausea and vomiting may cause a loss of body cell mass and result in electrolyte imbalances or dehydration.[22] If the problem is persistent and unrelated to drug therapy, organic causes, (e.g., infectious, gastrointestinal, or malignant) may exist and require appropriate treatment.

However, in most cases bouts of nausea and vomiting are temporary and intermittent, brought on as a complication of drug therapy. A decision to employ nutrition support depends on the etiology and duration of the nausea and vomiting, and the anticipated outcome of drug therapy.

Recommendations

The best way to establish food tolerances is through trial and error. Manipulate the diet to include easily digested foods, and avoid greasy, high fat, and spicy foods. Provide crackers, dry cereal, or toast in the morning. Encourage the intake of clear liquids or carbonated beverages between meals. Eliminate fluid intake, including soup, during meals. Provide small, frequent meals to avoid an empty stomach. Advise against foods with strong aromas. When cooking near patient, suggest air be cleared to avoid lingering odors.

Time meals and medications to avoid anticipatory vomiting. For example, dispense drugs that induce nausea or vomiting well in advance of mealtime. Provide antiemetic drugs prior to meals. Supplement food intake with an enteral formula that is calorically dense and adequate in protein. If nausea and vomiting are due to drug treatment, if treatment is expected to persist longer than two weeks, if prognosis is good, and/or if unintentional weight loss of 10% or greater has occurred, prescribe nutritional support.



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When oral intake remains suboptimal for seven days, consider peripheral parenteral nutrition for hospitalized patients for short term use of under 10 days. If a route such as a small bore enteral formula, and adjust administration for iso-osmolality.

Bowel Disease/Diarrhea

Rationale

Diarrhea is often the initial gastrointestinal symptom.[23] It may be associated with malabsorption due to villus abnormalities, producing a defective mucosal barrier. When mucosal damage occurs, bacterial and fungal translocation may result, increasing the chance of sepsis.[24] Despite multiple pathophysiologies, the causes of AIDS enteropathies can be divided into four categories: total small bowel disease, partial small bowel disease, large bowel disease, and nonspecific enteropathy.[25]

Diarrhea resulting from total small bowel disease, or jejunoileitis, is usually pan-malabsorbing and may not be treatable.[26] Stool volume is related to food intake, especially intake of dietary fats. Although individuals do not maintain body mass and appear anorectic or marasmic, they may be energetic, afebrile, and have a good appetite, though little endurance.

Partial small bowel disease is usually an ileal dysfunction which symptomatically resembles Chron's disease of the ileum.[27] Some cases may have specific pathogens, such as cytomegalovirus (SMV) or *Mycobacterium avium intracellulare* (MAI). The malabsorption is less severe than jejunoileitis. Diarrhea is primarily bile-salt induced and is intermittent and copious, especially in the morning. The volume of diarrhea increases with food intake. Losses involve fluid, electrolytes, and selected nutrients, such as vitamin B_{12}.[28]

Large bowel disease, or colitic enteropathy, is a generalized inflammatory disorder that, when chronic, causes rapid and progressive wasting in people with AIDS. Diarrhea is severe and is affected by food intake; therefore eating avoidance is common among some individuals, and may cause or exacerbate malnutrition.[25] There is no diagnosable pathogen in nonspecific enteropathy. The frequency of bowel movements is greater than normal but unrelated to food intake, and clinically resembles irritable bowel syndrome.[25] Appetite is preserved, but there is minimal malabsorption and weight loss.[25]

Recommendations

Total Small Bowel Disease. Because malabsorption is so severe in this enteropathy, it is the only instance in which calories should be delivered parenterally as the first choice. If the condition is partially or totally reversed, provide a minimal fat (less than 5%), lactose-free diet to stimulate gut function. This criteria can best be met with an elemental enteral diet. Since hypoalbuminemia with increased interstitial edema is a manifestation of malnutrition and may also contribute to diarrhea, monitor serum albumin and adjust nitrogen intake to promote its repletion.[29]

Partial Small Bowel Disease. Prescribe small, frequent feedings, which consist of low fat, low-lactose and caffeine-free foods. Encourage maximum caloric intake early in the day. Recommend a low fat formula to decrease bile salt flow. When ileal function becomes severely limited, and bile salts entering the colon result in steatorrhea with fatty acid diarrhea,[30] recommend an elemental diet (defined formula with less than 5% fat).

Large Bowel Disease. Encourage individuals with large bowel disease to consume small, frequent feedings that are low in fiber, residue, lactose, fat, and caffeine, to minimize the number of bowel movements.

Nonspecific mild enteropathy. Provide a bulking agent, such as bran or pectin, to solidify stool consistency. When nutrition support is indicated, provide an enteral formula. If condition worsens, or persists beyond two to three days, change to a less complex formula.

Table II summarizes feeding recommendations.

Infection and Sepsis

Rationale

Since people with AIDS are immunocompromised, they are particularly susceptible to infection and sepsis.[31] Metabolic and physiological consequences of infection, such as hypermetabolism, urinary losses, negative nitrogen bal-

Table II. Bowel Disease/Diarrhea

	Clinical Diagnosis	Diet Modication	Enteral Formula Administration	Parenteral Administration
Small Bowel Disease	Biopsy or Absorption tests	• Fat less than 20% • Low fiber • Low residue • Lactose-free • Avoid caffeine	(Only with partial or total reversal) • Low residue • Low lactose • Fat less than 5% e.g. elemental	Primary feeding route
Partial Small Bowel Disease	Exclusion or x-ray	• Fat less than 20% • Low residue • Low lactose • Avoid caffeine	• Low residue • Low lactose • Fat less than 5% e.g. elemental • Low fiber	Rarely indicated
Large Bowel Disease	Endoscopy and/or biopsy	• Low fat or MCT* • Low fiber • Low residue • Low lactose • Avoid caffeine	• Low residue • Low lactose • Low fat, as tolerated • Low fiber	Rarely indicated
Nonspecific Enteropathy	• No identifiable pathogen • Volume and frequency of stools	• Include bulking agent (pectin) • Low lactose • Low fat, as tolerated	• Low lactose • Low fat, as tolerated	Rarely indicated

*MCT = medium chain triglyceride

ance, and catabolism can affect nutritional status.[32] The synergistic effect of nutritional deficiencies and recurrence of infection may impair the body's ability to fight complications of infection.

Certain amino acids, such as glutamine, a primary energy substrate for the small intestine,[33] are currently being studied to determine whether there are increased requirements during stressed states.

Recommendations

Given that in septic patients Basal Energy Expenditure increases 7% for every degree Fahrenheit of body temperature over normal, adjust estimates of caloric needs for the febrile individuals.[34] Although this calorie recommendation may not be attainable, the goal is to meet these needs as closely as possible.

If dietary intake is not adequate, and nutritional needs cannot be met with a calorie-dense oral supplement, initiate an enteral tube feeding. Parenteral feedings may be associated with catheter-related septic complications; therefore they should be used only when aggressive nutrient repletion is desired for longer than seven to ten days during which the GI tract is unavailable. However, it may not be advisable to give iron parenterally in the presence of sepsis.[35] Because septic patients may be glucose intolerant, adjust dilutions so formulas are iso-osmolar. Monitor for hyperosmolar complications. Encourage the use of insulin to maintain a blood sugar of less than 200mg/dl.

Neurological Diseases

Rationale

Central nervous system manifestations of AIDS, ranging from psychomotor retardation to severe dementia, can significantly affect the individual's ability to maintain adequate nutritional status. The result may be reduced appetite, impaired ability to self-feed, and altered metabolic activity. When sensorium is depressed, the risk of aspiration is heightened.

It may be difficult to separate the effects of AIDS complications from the effects of PCM and/or specific nutrient deficiencies on the central nervous system.[36] Therefore, some malnourished patients may be showing neurological and behavioral abnormalities that are, in fact, induces by malnutrition and are reversible.

Recommendations

Conduct appropriate diagnostic procedures to determine the cause of central nervous system impairment. If malnourishment is suspected, introduce a short term trial of moderate doses (5 to 10 times the RDA) of micronutrients to ascertain whether nutritional deficiencies are responsible for the observed dementia.

For patients unable to feed themselves because of neurological difficulties, encourage assistance from the family or nursing staff.

Include the family or friends, the primary caregiver, and the patient's prior wishes in the decision to provide non-volitional nutrition support in people with severe dementia and a poor prognosis.

Conclusions

Since clinical research is not yet available on nutrition and AIDS, the recommendations in this report are based on extrapolations from other chronic diseases and from the personal experiences of the Task Force members.

It is essential that studies be conducted in people with AIDS to determine nutritional requirements during various stages of the disease and its complications. However, because of the urgent need for proper nutritional management certain conclusions can be drawn.

* All patients should have a complete nutritional assessment on initial contact with a health professional. This includes the Asymptomatic individual, identified as HIV positive.
* The major aim of all nutritional therapy is to minimize loss of lean body mass and to prevent deficiencies of all micronutrients. To this end, oral food intake is the first choice for providing good nutrition. When this is not possible enteral nutrition, using various routes, must be considered.
* Only when the enteral routes are not feasible should parenteral nutrition be used.
* Because malnutrition can complicate the course of AIDS, nutritional support should be given before the patient becomes malnourished. Thus, an aggressive approach to nutritional therapy is advocated at each stage of the disease.
* Although the use of nutritional supplementation in the form of multivitamin and mineral preparations containing 100% of the RDA for all micronutrients is acceptable to insure micronutrient sufficiency, there is no evidence that megadoses of any vitamin or mineral will alter the course of AIDS or further improve the nutritional status of the patient.
* In anticipation of a rapid proliferation of drugs used to treat AIDS, special attention must be paid to drug-nutrient interaction.
* Because of the complex nature of the disease, a multidisciplinary team approach involving a physician, a dietitian, and a nurse is indicated for optimal nutrition management.

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Appendix A

Step 1. To calculate basal energy expenditure, use the Harris-Benedict equation.

For men: $BEE = 66 + (13.8 \times W) + (5 \times H) - (6.8 \times A)$

For women: $BEE = 655 + (9.6 \times W) + (1.8 \times H) - (4.7 \times A)$

BEE = basal energy expenditure
W = weight in kilograms
H = height in centimeters
A = age in years

Source: Harris JA, Benedict FG. A biometric study of basal metabolism in man. Washington, DC, Carnegie Institution of Washington, 1919, Vol. 2, p.227

Step 2. To determine individual caloric needs:

BEE x ACTIVITY FACTOR x INJURY FACTOR

ACTIVITY FACTOR:

Confined to bed	1.2
Ambulatory	1.3

INJURY FACTOR:

Surgery	1.1	-	1.2
Sepsis	1.2	-	1.6
Trauma	1.1	-	1.8
Burn	1.5	-	1.9

Step 3. To determine individual protein needs:

Protein needs =

$$\text{Total Calories} \times \frac{\text{gm nitrogen}}{150} \times \frac{6.25 \text{ gm protein}}{\text{gm nitrogen}}$$

APPENDIX B

Reference Standards for Sum of Triceps and Subscapular Skinfold*

Age Group (yr)	Percentile						
	5	10	25	50	75	90	95
	American Men						
18–74	11.5†	13.5	19.0	26.0	34.5	44.0	51.0
18–24	10.0	12.0	15.0	21.0	30.0	41.0	51.0
25–34	11.5	13.5	19.0	26.0	35.5	45.0	54.0
35–44	12.0	15.0	21.0	28.0	36.0	44.0	48.5
45–54	13.0	15.0	21.0	28.0	37.0	46.0	53.0
55–64	12.0	14.0	20.0	26.0	34.0	44.0	48.0
65–74	11.5	14.0	19.5	26.0	34.0	42.5	49.0
	American Women						
18–74	18.5	22.0	28.5	39.0	53.0	65.0	73.0
18–24	17.0	19.0	24.0	31.0	41.5	54.5	64.0
25–34	18.5	20.5	26.5	35.0	48.0	64.0	73.0
35–44	20.0	23.0	30.0	40.5	55.0	68.0	75.0
45–54	22.0	25.0	33.5	45.0	58.0	69.5	78.5
55–64	19.0	25.0	33.0	46.0	58.0	68.0	73.0
65–74	20.0	25.0	32.0	41.0	52.2	63.0	70.0

*Developed from data collected during the Health and Nutrition Examination Survey of 1971–1974.[133]
†Values are in mm.

Reference Standards for Midarm Muscle Circumference*

Age Group (yr)	Percentile						
	5	10	25	50	75	90	95
	American Men						
18–74	26.4†	27.6	29.6	31.7	33.9	36.0	37.3
18–24	25.7	27.1	28.7	30.7	32.9	35.5	37.4
25–34	27.0	28.2	30.0	32.0	34.4	36.5	37.6
35–44	27.8	28.7	30.7	32.7	34.8	36.3	37.1
45–54	26.7	27.8	30.0	32.0	34.2	36.2	37.6
55–64	25.6	27.3	29.6	31.7	33.4	35.2	36.6
65–74	25.3	26.5	28.5	30.7	32.4	34.4	35.5
	American Women						
18–74	23.2	24.3	26.2	28.7	31.9	35.2	37.8
18–24	22.1	23.0	24.5	26.4	28.8	31.7	34.4
25–34	23.3	24.2	25.7	27.8	30.4	34.1	37.2
35–44	24.1	25.2	26.8	29.2	32.2	36.2	38.5
45–54	24.3	25.7	27.5	30.3	32.9	36.8	39.3
55–64	23.9	25.1	27.7	30.2	33.3	36.3	38.2
65–74	23.8	25.2	27.4	29.9	32.5	35.3	37.2

*Developed from data collected during the Health and Nutrition Examination Survey of 1971–1974.[133]
†Values are in cm.

Source: Buzby GP, Mullen JL: Nutritional assessment. In: Rombeau JL, Caldwell MD (eds): *Enteral and Tube Feeding Volume 1.* Philadelphia, WB Saunders Co, 1984, p 127.

AIDS IN ARKANSAS 1989
January 1 - September 27, 1989

Total number of cases reported	57
Number of deaths	28

CASES BY SEX

Male	51
Female	6

CASES BY RACE

White	41
Black	15
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	38
Homosexual & IV Drug User	5
IV Drug User	6
Hemophiliac	1
Transfusion	1
Heterosexual (Contacts)	5
NIR#	1

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	1
20 - 29	17
30 - 39	29
40 - 49	6
50 - 59	3
60 or more	1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	19
Kaposi's Sarcoma	3
Pneumocystis Carinii and Kaposi's Sarcoma	0
Other Diseases	35

AIDS IN ARKANSAS
1985 - 1989

Total number of cases reported	230
Number of deaths	143

CASES BY SEX

Male	213
Female	17

CASES BY RACE

White	176
Black	52
Other	2

CASES BY RISK GROUP

Homosexual/Bisexual	152
Homosexual & IV Drug User	27
IV Drug User	23
Hemophiliac	2
Transfusion	10
Heterosexual (Contacts)	12
NIR#	4

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	3
20 - 29	75
30 - 39	103
40 - 49	32
50 - 59	9
60 or more	8

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	102
Kaposi's Sarcoma	11
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	111

Source: Arkansas Department of Health.



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Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The Antidumping Statute



J. David Busby, M.D.*, ABFP, ABQAURP
Arkansas Foundation for Medical Care

The Consolidated Omnibus Budget Reconciliation Act of 1985 was signed into law by President Reagan on April 7, 1989. This law contains several provisions that directly effect health care providers and practitioners. Section 9403 of that law and other public laws will require, when implemented, that the PRO deny payment for substandard quality of care. The Notice of Proposed Rules have been issued but the final rules have not been developed.

The Antidumping Statute of the Consolidated Omnibus Budget Reconciliation Act (COBRA), however, has been implemented. It requires that every Emergency Medical Department screen any individual presenting to an Emergency Room to determine if the patient has an emergency medical condition or if the patient is in active labor. The statute defines an emergency medical condition as:

> "Any condition manifesting itself by acute symptoms including severe pain, in which the absence of treatment could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function or serious dysfunction of any body organ or part."

The law defines active labor as:

> "Labor at a time at which delivery is imminent, there is inadequate time to effect safe transfer to another hospital prior to delivery, or a transfer may pose a threat to the health and safety of the patient or the unborn child."

Generally, most practitioners and health care providers have interpreted the antidumping statute to relate to those patients that are transferred. However, failure to provide an appropriate screening examination within the hospital's capacity violates Section 1867 of the Social Security Act which became effective August 1, 1986.

When a screening exam indicates that a patient has an emergency medical condition or that the patient is in active labor (as defined by the Statute), the hospital must provide for treatment to stabilize the patient prior to any appropriate transfer.

The patient does not have to be stabilized if the patient or the patient's legal representative requests the immediate transfer or a physician signs a certification that the benefits of transfer outweighs the risks.

Transfer has been defined liberally to include the movement of a patient outside of a hospital's facility at the direction of any person employed by (or affiliated or associated directly or indirectly with) the hospital. This includes a patient who is sent home or the one who dies or delivers en route to the intended receiving hospital. This does not include the patient who has been declared dead or who leaves the facility without permission.

The transfer must involve a person who had entered the hospital by way of the Emergency Room to be considered under the Antidumping Statute.

For a transfer to be considered appropriate, there must be documentation that the receiving facility has available space and qualified personnel, has agreed to accept the transfer and provide the appropriate treatment. The transferring hospital must provide the receiving facility with copies of the medical record of their treatment provided prior to transfer and the transfer must be effected through qualified personnel and transportation equipment including life-support measures as may be medically necessary and appropriate during the transfer.

The Antidumping Statute provides stiff penalties related to violations. They include:

1. The Health Care Financing Administration may terminate the hospital's provider agreement or the Office of Inspector General (OIG) may suspend the hospital from participation.
2. The OIG may impose a monetary penalty against the hospital and the "reasonable physician" who may be employed by or under contract with the hospital and, in that capacity, have professional

* Medical Director, Arkansas Foundation for Medical Care, Post Office Box 2424, Fort Smith, Arkansas 72902-2424.

responsibility for the examination, treatment or transferring the patient.''

3. The penalty was raised from $25,000 to $50,000 for each violation that occurs on or after December 22, 1987.
4. For two years following the date of the violation, an individual who suffers personal harm as a result of a violation or a medical facility which suffers a financial loss, may obtain damages in a civil action under the state laws.

As of June 30, 1989, the Dallas Regional Office of the Health Care Financing Administration has received 122 reports of COBRA violations from the five-state region.[1]

Proposed regulations on June 16, 1988 would require that the HCFA terminate Medicare agreements with offending hospitals with just two days notice and would require that a hospital promptly report a suspected violation or be subject to termination.

As of June 30, 1989, the Dallas Regional Office of the Health Care Financing Administration has received 122 reports of COBRA violations from the five-state region (Texas, Arkansas, Louisiana, Oklahoma, New Mexico).[1] Three cases were listed as ''pending'', 74 were listed as ''no violation'' and 43 were ''confirmed to represent violations.'' The 43 violations represented 12 from urban hospitals and 31 from rural hospitals. Nineteen of the violations were related to OB patients and 24 to non-OB patients.

Fourteen investigations were started after notification by the receiving hospital, 14 after notification by the survey agency, 3 after notification by the PROs, 2 after notification by police, 5 after notification by the patient or the family and 5 were anonymous.

Only two hospitals have been terminated from the Medicare Program because of COBRA violations. Both these hospitals were in Texas. Several monetary penalties that were imposed nationally have varied in amount; although five that were settled were for a total of $142,999.

In summary, the Antidumping Statute of COBRA has serious implications for health care providers and practitioners in the State of Arkansas. There must be documentation of screening examinations for patients. For patients with emergency medical conditions or in active labor, there must be documentation of stabilization, appropriate transportation of the patient and that the receiving hospital is willing and able to accept the patient.

References

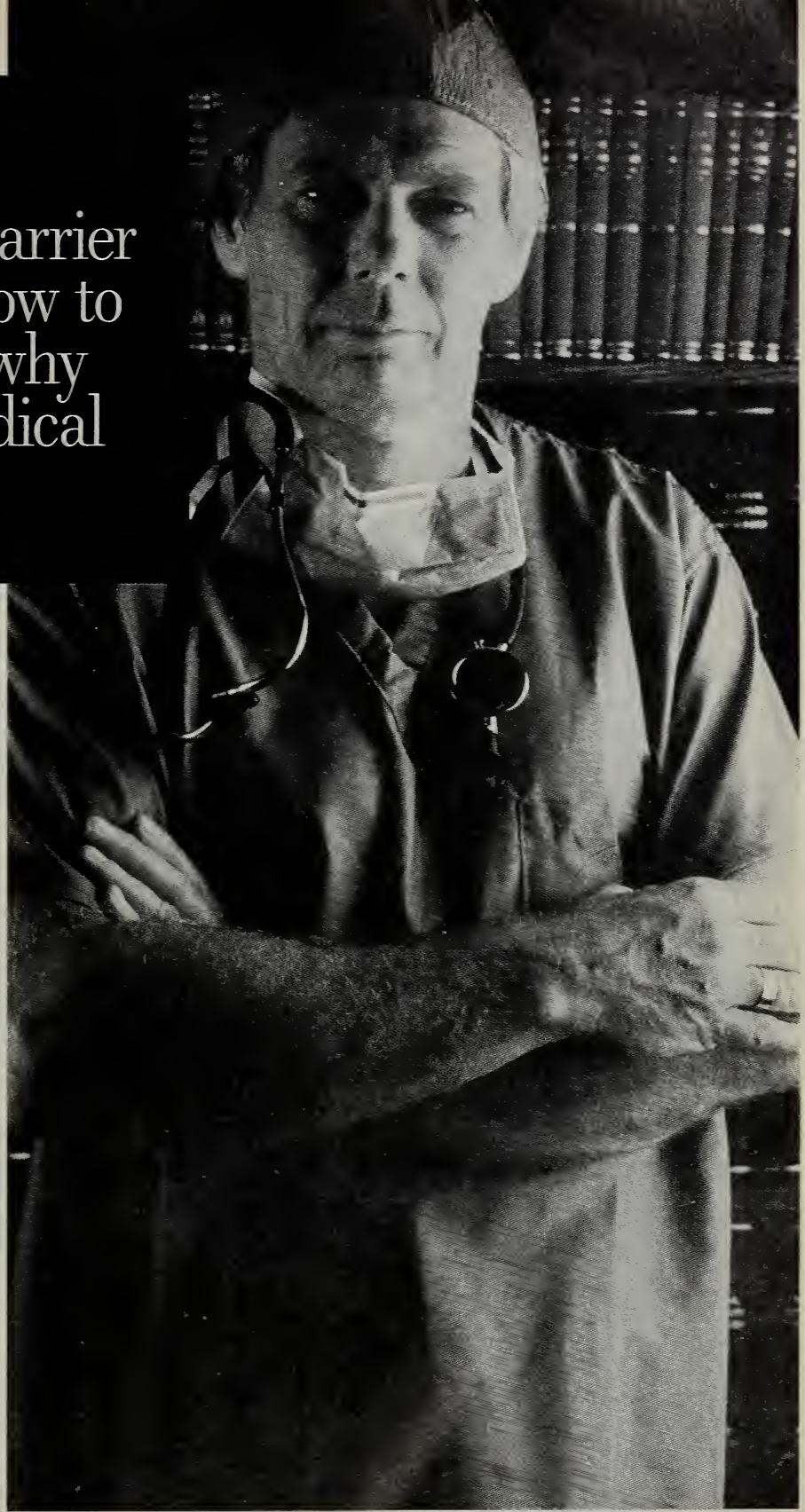
1. Dr. Ken Schneider, Associate Regional Administrator, Dallas Regional Office of HCFA, address to Region VI PROs, August 18, 1989.

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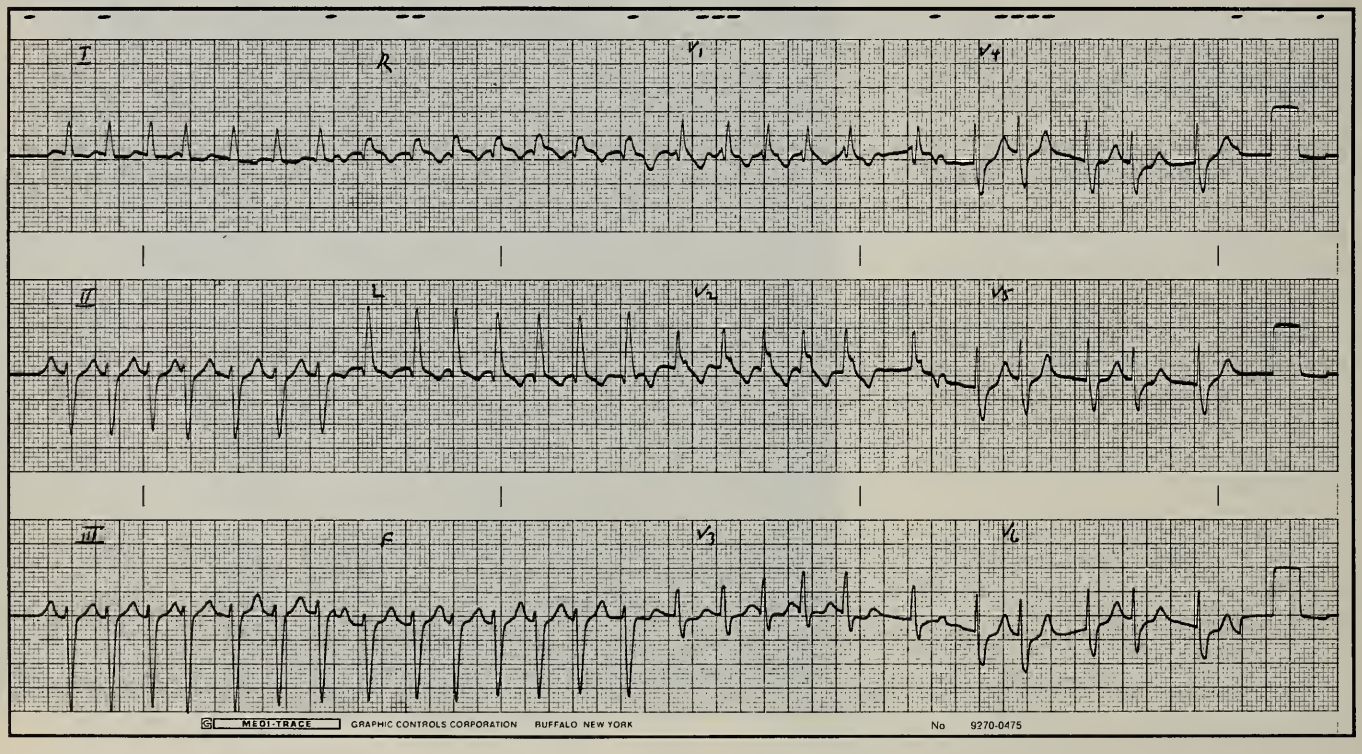


ELECTROCARDIOGRAM of the MONTH

William C. Furlow, M.D.
John W. Watson, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

CLINICAL HISTORY:

B. C. is a 55-year-old man who has presented for evaluation of nocturnal dyspnea and edema. The patient's history was positive for excessive use of alcohol. Physical examination revealed neck vein distension, an irregular irregularity of the cardiac rhythm, an S_3 gallop, signs of pleural effusion, and anasarca. What do you think about the electrocardiogram and the clinical situation in general?



DISCUSSION:

The mechanism is atrial fibrillation with a ventricular response of 170 beats per minute. Left anterior fascicular and right bundle branch block are noted. The ST-T segments are abnormal in a nonspecific manner. The patient's picture is compatible with heart failure. The patient proved to have dilated cardiomyopathy, a condition that could be suspected but not established on the basis of the information given in this brief sketch.

The editor wishes to thank Dr. Furlow for his assistance with this month's feature.

Pediatric Spinal Cord Tumors

William Chadduck, M.D.*

Fortunately, spinal cord tumors in children do not represent a common problem, but when they do occur, they account for considerable morbidity. Further, the insidious nature of their neurologic progression combined with the relative infrequency of the condition often makes the diagnosis difficult. A series of patients treated for spinal cord tumors at the Arkansas Children's Hospital will be presented to review the clinical findings of spinal cord tumors in children, to demonstrate newer modalities of imaging such as magnetic resonance scans, and intraoperative ultrasound, and to show how new technology and improvements in surgical technique have improved outcome.

Clinical Presentation

Progressive abnormalities of posture, noted when the child is standing, walking, or even recumbent, may represent the earliest clinical symptom of spinal cord tumor. In a series of 72 pediatric patients with spinal cord tumors reported by Rand and Rand,[4] weakness of an extremity, usually a leg, or backache, pain in the spine or extremity, or pain in an extremity alone occurred 60-70% of the time. Less common symptoms included a mass, abnormal gait, chest pain, and abdominal pain. Motor weakness of one or more limbs appears sooner or later in the presence of almost all neoplasms affecting the spinal cord. Delayed walking should also be viewed with suspicion. When the tumor is above the conus medullaris, weakness is usually of the spastic or upper motor neuron type, noted by hyper-reflexia, clonus and Babinski signs. If the neurologic deficit comes on rapidly, for example, following a fall or a spontaneous hemorrhage, initially flaccid paraplegia may be produced below the level of the lesion as a result of spinal shock.

Tenderness usually accompanies spinal pain and may be elicited by percussing the spine over or near the site of the tumor. Neck flexion may cause pain at the level of the tumor, traveling down the trunk into the lower extremities. An unusual position of the head, either bent forward or tilted in a wry neck position, may be a sign of a cervical spinal cord tumor. In some patients, increasing kyphosis or scoliosis may be the only sign of an intraspinal tumor. Muscle atrophy, reflecting lower motor neuron disease, indicates anterior horn cell or nerve root involvement. Whereas incontinence of urine in an untrained child may be of no consequence, constant dribbling may be a clue to a lesion of the cauda equina including tumor, dysraphism, or tethering of the spinal cord. Urinary retention is never physiologic in children, and usually signifies involvement of the spinal cord unless accountable by pharmacologic agents.

Diagnostic imaging

When a lesion of the spinal cord or intraspinal nerve roots is suspected, appropriate radiographs of the spine should be done to determine the presence or absence of spinal dysraphism, signifying a congenital anomaly. Myelography is no longer utilized for imaging spinal cord lesions. Not only is myelography more morbid, but may precipitate neurologic deterioration as can lumbar puncture.[3] CT scanning is limited by its axial confinement with longitudinal images frequently being computerized reconstructions, limited to segments of the spinal canal. On the other hand, magnetic resonance scanning has essentially revolutionized imaging of the spinal cord, as well as the spinal canal and adjacent

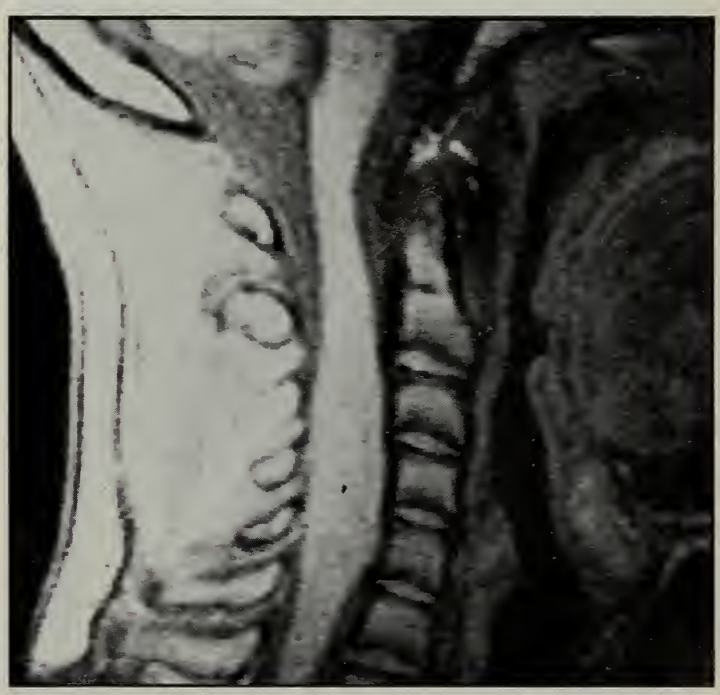


Figure 1. Sagittal view of a magnetic resonance image shows the marked enlargement of the cervical spinal cord (black dot) demonstrating a diffuse spinal cord astrocytoma.

* Arkansas Children's Hospital, 800 Marshall, Little Rock, Arkansas 72202.

vertebral structures. Magnetic resonance imaging is the diagnostic procedure of choice for spinal cord tumors, having the capability of showing tumor modules as well as associated cavitations of the spinal cord. Figure 1 exquisitely demonstrates a diffuse cervical spinal cord tumor. Vascular anomalies create a flow void which can clearly be depicted when present. Magnetic resonance angiography, utilizing the physical principle of flow void, promises to be developed to an even greater sensitivity. Contrast agents, such as gadolinium, now offer better resolution of the interface between tumor and normal neural tissue. Undoubtedly, other even more specific contrast agents will be developed in the future. In non-neoplastic diseases, such as Devic's disease, a primarily optic and spinal form of multiple sclerosis occurring in young people, magnetic resonance imaging can exquisitely show plaques of demyelination.

Pathology of pediatric spinal cord tumors

In the adult population, but far the most common neoplasm affecting the spinal cord is that of a metastatic tumor. In children however, metastatic spinal cord tumors are significantly less common, but do occur occasionally in association with the leukemias and lymphomas. Also, drop-metastases from malignant brain tumors, especially cerebellar medulloblastomas, occur with some regularity.

The primary spinal cord tumors are separated into intramedullary and extramedullary varieties. Extramedullary tumors are most often the neurofibromas or neurilemomas often associated with von Recklinghausen's disease. Spinal meningiomas in children are extremely rare. On the other hand, intramedullary tumors such as astrocytomas, and ependymomas are among the more frequent lesions. The astrocytomas are frequently cystic, containing a benign mural nodule amenable to total surgical removal. Approximately 10-20% of astrocytomas of the spinal cord are malignant and progressive, and many are diffuse and unresectable. The cystic components of these tumors in the past have often been mistaken for syringomyelia, but the fluid within the cyst generally has a high protein concentration. True syringomyelia or hydromyelia contains fluid essentially the same as cerebro-spinal fluid. Now that imaging modalities can show us the mural nodules and cysts rather than simply enlargement of the spinal cord, the surgical treatment may be directed precisely to the solid portion of the tumor. Ependymomas are generally derived from the ependymal cells lining

Table I. Pediatric Spinal Cord Tumors

Type	Number
Astrocytoma, benign	3
Astrocytoma, malignant	1
Ependymoma	2
Hemangioblastoma	1
Schwannoma	1
Lipoma	2
Cerebellar medulloblastoma	2

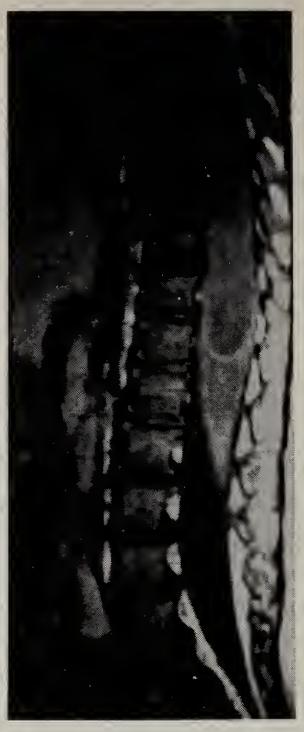


Figure 2. Sagittal view of a magnetic resonance image of a child with a holocord astrocytoma. The cystic portion of the tumor extends superiorly and the solid portion of the tumor extends inferiorly, terminating in the conus medullaris.

the central canal of the spinal cord. They frequently have calcifications, and may occur anywhere along the spinal axis. One specialized variety of ependymoma, the myxopapillary ependymoma of the conus medullaris is generally amenable to cure by surgical treatment done. Other ependymomas are diffuse, and incomplete resections have been treated with irradiation. Arteriovenous malformations and other vascular lesions of the spinal cord can simulate spinal tumors producing symptoms on the basis of hemorrhage or spinal cord ischemia. Intraspinal lipomas usually occur in the conus medullaris and are associated with dysraphism.

Patients and methods

Thirteen consecutive patients with pathologically proven spinal cord tumors are included in this report. Table I depicts the pathological diagnoses reflecting approximately the same distribution reported in earlier series. All of these recent patients, however, have had the benefits of newer diagnostic modalities and surgical adjuncts in their management.

The following case presentations serve to illustrate the variety of tumors and newer modalities for diagnosis and treatment. Four of the patients had intramedullary astrocytomas, two being in the cervical region and two in the lumbar. Figure 2 shows the intramedullary tumor nodule and cystic portion of a cystic astrocytoma in a 22-month-old girl with delayed walking and scoliosis. In this patient, the cystic portion of her tumor extended all through the spinal cord, even to the point of distending the cervico-medullary junction. As noted by Epstein,[2] these holocord astrocytomas are frequently associated with a solitary nodule, amenable to surgical removal. Using intraoperative ultrasound, the tumor nodule was identified, limiting the extent of the laminectomy. At the time of the dissection, the neoplastic tissue could be removed up to the point of normal cord, also identified by intraoperative ultrasound. Using microsurgical



Figure 3. Sagittal MRI of the lumbar spine of a patient with a neurilemmoma (arrow) of ther terminal spinal cord producing a lumbar disc syndrome.

technique, the appropriate region of the spinal cord could be opened, and using an ultrasonic aspirator, tractionless dissection of the intramedullary tumor was accomplished. The operating microscope was helpful in better visualizing the demarcation of the tumor from normal spinal cord tissue. Post-operatively, the child had no increase in neurologic deficit, and has had no progression of tumor as shown by magnetic resonance imaging. Prior to magnetic resonance imaging, this patient would have been considered to have a diffuse astrocytoma involving the entire spinal cord, and may have been surgically treated with cyst drainage, biopsy, and spinal axis irradiation, now considered inappropriate for this lesion.

Another patient, only two-years-old, began having trouble walking and repeatedly fell to one side. His examination showed diffuse weakness of the right arm and had spastic weakness of the right leg and loss of the pain sensation in the left, consistent with a Brown-Sequard syndrome. Magnetic resonance imaging disclosed a diffuse intramedullary lesion in the cervical spinal cord. Delineation of the tumor from normal spinal cord tissue was virtually impossible without the use of intraoperative ultrasound. In this case, total removal was not possible so that biopsy and radiation therapy became the treatment of choice. Without these adjuncts, random biopsy of an expanded, but otherwise normal-appearing spinal cord, would have been the only option.

A teen-age patient with spinal pain and numbness in the left foot was thought to have a lumbar disc herniation. CT scanning of the L-4 and L-5 discs showed no abnormalities, exemplifying the inadequacy of this test for studying lesions of the cauda equina. A magnetic resonance scan (Figure 3) readily demonstrated a tumor at L1. At surgery, the lesion could be visualized using intraoperative ultrasound so that total removal could be accomplished through a hemi-laminectomy, avoiding the destabilizing complications of a more extensive laminectomy. Cure, with neither neurological deficit nor spinal instability, was appreciated.

A four and a half-year-old boy was referred for evaluation of an inturning of his right leg. His examination showed wasting of the right gluteal, hamstring, and gastrocnemius muscles, as well as foreshortening of the right leg. Sensory examination, however, was normal. He also has a cafe au lait spot in the distribution of an upper lumbar nerve root on the right side. He became incontinent of urine, and lost control of bowel function. MRI scanning (Figure 4) showed a tumor in the region of the conus medullaris. Intraoperative cystometrics were used to monitor function as the tumor was removed. Microsurgically, the spinal cord was opened and a plane identified between the infiltrating astrocytoma and spinal cord. Patchy residual areas were vaporized with a carbon dioxide laser system. Intraoperative ultrasound showed the central canal of the normal distal spinal cord at its interface with the tumor. Post-operatively, the patient had no loss of neurologic function and in fact, had preservation of perineal sensation.

Results

Eleven patients had 13 operations. One patient was operated three times and two patients with metastatic cerebellar medulloblastoma were treated with experimental chemotherapy protocols. There was no operative mortality. Nine of the surgically treated patients were improved post-operatively. One patient was neurologically worse after his third operation for a recurrent cervical cord ependymoma, but has gradually improved. Two patients, paralyzed at the



Figure 4. A coronal view of the magnetic resonance image of a patient having a tumor of the conus medullaris. The bright mass in the midline shows the astrocytoma. To the right is an image of the kidney.

time of neurosurgical consultation, were not helped by decompressive laminectomy in one case and intramedullary tumor removal in another.

Table II. Spinal Cord Tumor Treatment Improvements

Modality	Use
Intraoperative somatosensory evoked potentials	Monitors spinal cord function during surgery
Intraoperative cystometrics and anal sphincteric transducers	Monitors conus medullaris function during surgery
Operativing microscope and microsurgical instrumentation	Allows precise dissection winthin spinal cord
Intraoperative real-time ultrasound imaging	Allows intraoperative visualization of spinal cord pathology: cysts, tumor nodules and differentiation from normal spinal cord
Ultrasonic aspiration	Allows trantionless dissection
Carbon dioxide laser	Allows vaporization of residual tumor and hemostasis

Discussion

It has long been known that patients presenting with total paraplegia or quadriplegia from spinal cord tumors are very infrequently benefitted by surgical treatment. The results in this series reconfirm the fact that such patients do not respond to surgical decompression at that stage of their disease. Further, Epstein[2] has clearly shown that the outcome of pediatric patients with spinal cord tumors is directly related to the amount of preoperative neurological deficit. Thus, it is clear that early diagnosis of pediatric spinal cord tumors does affect eventual outcome, calling for early recognition of symptoms and signs of this relatively infrequent disease process.

The morbidity of diagnostic procedures for patients suspected of having spinal cord tumors has been significant in the past, a factor certainly to be considered in pursuing relatively minor neurologic symptoms. On the other hand, with the advent of magnetic resonance imaging, a noninvasive imaging technique, not even associated with exposure to radiation, there is little reason to hesitate in obtaining a definitive diagnostic examination, even in patients with minimal neurologic symptoms or signs. Although the yield numerically may not be great, the potential benefit for a patient diagnosed early, can be exceptionally rewarding.

Newer techniques in surgical management also make early diagnosis even more important, and add to the somewhat improved outcome in pediatric patients having spinal cord tumors. Intraoperative ultrasound[1] has been demonstrated to have a significant impact on surgical treatment. Not only is the operating surgeon able to distinguish normal spinal cord from infiltrating tumor, to differentiate cystic cavities from solid tumor, but is also able to limit the amount of bone removal potentially destabilizing in the pediatric spine.

The newer surgical adjuncts such as the ultrasonic aspirator allow tractionless dissection of tumors with minimal trauma to the adjacent neural tissue. The role of the carbon dioxide laser has also been defined in the surgical management of spinal cord tumors. Large masses of tumor are best removed with the ultrasonic aspirator, since the laser produces considerable heat in vaporizing the tissue. When small volumes of residual tumor remain, these can be safely vaporized with the laser system, also helpful in hemostasis.

The ability to monitor spinal cord function throughout the course of the operation guides the surgeon in an especially helpful way when abnormal tissue is being dissected away from relatively preserved spinal cord tracts.

In the past, oftentimes spinal cord tumors have been treated by biopsy and radiation. This approach reflected in part the frustration in managing patients with inadequate imaging capabilities and limited surgical technology. Whereas there has been a considerable improvement in the management of pediatric patients with spinal cord tumors, there remains a need for ongoing research, development, and improvements in both neurologic outcome and longevity. The medical-legal liability of operating on a child with a disease process associated with such high neurologic morbidity, has made many neurosurgeons reluctant to undertake operations on pediatric patients with some types of spinal cord tumors. Nonetheless, the obligation for early diagnosis and neurosurgical referral of such patients remains the continued responsibility of all physicians treating children.

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Carcinoma of the Thyroid Metastatic to Regional Lymph Nodes

Raymond L. Marecek, M.D., Anthony P. Bucolo, Jr., M.D., William E. Atkinson, M.D., Harold D. Langston, M.D., Jerry L. Prather, M.D., and Harriet Farley, M.S.W.

A 32-year-old female presented with questions as to her future treatment and prognosis after a near total thyroidectomy and modified right neck dissection for mixed papillary follicular carcinoma in October, 1987. The patient had a postoperative course that was uncomplicated and was discharged home on Synthroid 200 mcgs. q. day. She received a whole body iodine scan on February 2, 1988 and had discontinuance of the Synthroid approximately 4 weeks prior to the scan. The scan showed residual right and left lobes of the thyroid. Patient was admitted on February 8, 1988 for I-131 ablative therapy. A calculated dose of 50 mci. was administered in order to attain ablation of the thyroid remnants.

Pathology Review

Dr. Atkinson: Mixed papillary and follicular adenocarcinoma of the thyroid with regional node metastases.

Diagnostic X-ray Examination

Dr. Prather: The thyroid scans and chest x-rays of the patient were reviewed for the panel. Radioisotopic thyroid scanning has been useful in delineating the poorly functioning "cold" nodule from a "hot" hyperfunctioning mass. A "cold" nodule is suspicious of cancer, but is more commonly a colloid cyst, hemorrhage, or a solid thyroid adenoma. The "warm" nodule, which concentrates isotope equal to adjacent thyroid tissue, may be troublesome diagnostically and may harbor a cancer. Normally functioning thyroid tissue surrounding a "cold" nodule may mask its hypofunction. A "warm" nodule that fails to suppress with exogenous thyroid is autonomous, and like the "hot" nodule, is unlikely to be cancerous. The main choices for preoperative thyroid scanning are Iodine-123 and Technetium 99m with their short half-life, low radiation dose, useful energy peak, and physiologic behavior of labeling functioning tissue but not cancer. The ultrasound evaluation of the thyroid of this patient was also reviewed.

Medical Oncology Opinion

Dr. Bucolo: Thyroid cancers are usually characterized by slow growth, delayed symptoms, minimum morbidity and low mortality. Chemotherapy is not indicated except for metastatic disease where Doxurubicin (Adriamycin) appears to be the most promising drug.

Endocrinology Opinion

Dr. Marecek: The utility of a thyroid scan was discussed in relation to the risk involved and the elevation of the thyroid stimulating hormone (TSH) in preparation for the scan. Exogenous thyroid in high doses will suppress TSH and will probably induce regression in any residual tumor. Therefore, it is preferable to avoid any needless interruption of suppressive therapy. Monitoring the effectiveness of the suppression by chest x-ray, TSH radioimmunoassay and thyroglobulin was discussed.

Radiation Therapy Opinion

Dr. Langston: Small or residual papillary cancers can be controlled by postoperative external irradiation. An ablative dose of 30-50 millicuries of Iodine-131 is usually given postoperatively on the basis of evidence of residual tissue at the thyroid site. Ablation seemed to work well with this patient.

Consensus

The panel felt that the patient had received state-of-the-art treatment and treatment was timely and appropriate.

The panel recommended that a close clinical follow-up was the best approach following ablation with I-131. It was the recommendation of the panel that a thyroglobulin level as well as a TSH, a chest film and a physical examination should be performed at three month intervals during the first year and at six month to one year intervals thereafter. The panel felt that a follow-up iodine whole body scan may be helpful.

St. Vincent Cancer Center, St. Vincent Infirmary Medical Center, Two St. Vincent Circle, Little Rock, Arkansas 72205.

The Mayo Clinic study[1] of some 859 patients with thyroid carcinoma over a maximum follow-up period of 39 years was discussed with the patient. The panel felt that over the years her longevity would not be significantly influenced, given her tumor type, excellent surgical care and radioactive treatment.

It was explained that there was legitimate disagreement as regard to following thyroid carcinoma with scans, however, the recent studies pointed toward thyroglobulin levels as being very helpful and a more sensitive means of detecting early recurrence than the more laborious and time consuming scans.

The panel felt that the patient's prognosis was excellent should she stay on thyroid suppressive therapy, be followed with thyroglobulin and TSH level, chest films and physical examinations at appropriate intervals. She was advised not to get pregnant for at least one year. The patient also met with the social worker for counseling.

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Occupational Medicine: A Challenge for the Primary Care Physician

Paul Rountree, M.D.,* Mona Ray Fields, Ed.D., R.N., Mary Ann Coleman, B.S.

Occupational medicine is that specialty of practice involving the recognition, prevention, and treatment of illness or injury arising out of the workplace. It is a recognized subspecialty of the American Board of Preventive Medicine, but only about one-fourth of 4,000 physician members of the American College of Occupational Medicine (ACOM) are certified. Occupational medicine is one of the most exciting and rapidly growing areas of medical practice. The National Institute for Occupational Safety and Health (NIOSH) has estimated that there are less than 10% of the number of needed physicians in this specialty. There are only nine members of ACOM in Arkansas, and four of these are retired.

Discussion

In our state, job-related injury or illness is managed almost exclusively by the primary care physician whose knowledge and clinical skill allows him to be in a unique position to diagnose and treat these problems. In fact, industries today are more likely to contract with a primary care physician for occupational health services than to hire a physician as an employee of the company.

Free-standing industrial medicine clinics, common in some areas of the country, are being challenged by emergency physicians and hospitals. The treatment of job-related injury is viewed as a way of enhancing patient volume. At present occupational health clinics are provided by 46% of hospitals in the United States. An additional 16% plan to include these services in the near future.[1]

Multispecialty group practices are also interested in occupational medicine. A recent survey suggests that a three-fold increase in occupational health activity will occur in private group practices within the next decade.[2]

Finally, it is important to note that non-physicians are increasingly involved in occupational or industrial health. Companies may contract with private nurse practitioners to provide occupational health services. Other entrepreneurs, many with little medical training, develop and sell programs in fitness, health promotion, smoking cessation, stress management, and nutritional counselling.

Millions of dollars are spent in Arkansas each year for medical care of workers with injuries sustained at the jobsite. Exact figures are difficult to obtain because workers are covered by a variety of different programs and each has a unique reporting system (for example, in 1987, workers' compensation spent more than 55 million dollars collectively on hospital, medical, and pharmacy charges in Arkansas.[3] This figure does not include the costs for federal employees nor some other groups such as railroad employees, who have their own system for workers compensation.

Millions of dollars are spent in Arkansas each year for medical care of workers with injuries sustained at the jobsite.

Substantial funds are also expended by industry for pre-placement examinations or periodic evaluation mandated by regulatory authorities. Some companies pay for health promotion and screening programs as well.

Job-related injury is generally recognized, but job-related illness is underdiagnosed. Exposures at the jobsite may cause or aggravate diseases of any organ system. Today's patients are increasingly aware of exposure to hazardous chemicals from industry. Since the end of World War II, our nation has become the major producer of industrial chemicals in the world. We are the largest per capita hazardous waste producer in the world. In spite of this, the National Academy of Science has estimated that we have adequate toxicologic data on less than 20% of commonly used chemicals.[4] Reports of disasters such as those at Bhopal and Love Canal are dramatic. Major chemical spills receive their share of publicity. New government regulations require industry to notify employees and their community of the hazardous materials stored or used by the plant.

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Few issues in occupational medicine are as controversial ...as drug screening programs. ...Employers hope to achieve worksite safety and improve job performance. A recent survey[7] indicated that employers in Arkansas rank this as their leading health issue.

Manufacturers or users of industrial chemicals are required to provide a material safety data sheet (MSDS) upon request to any employee or members of the community who desires information. As a result of this barrage of information, it no surprise that physicians are asked whether symptoms may have been caused by chemicals.

Physicians may be unaware of exposure to chemical vectors of disease. Over 250 years ago, Bernardo Ramazini advised physicians to remember to ask their patients about their occupation as a part of the medical history,[5] but in contemporary clinical practice the majority of medical records fail to indicate the patient's job, and a careful occupational history is rarely included. Occupational medicine is a required part of the curricula in only 30% of medical schools in this country, and in those institutions the median time spent on instruction is four hours.[6]

Few primary care physicians are comfortable with their knowledge of toxicology. Information about chemicals may be difficult to obtain and reference sources are unfamiliar. Chemicals may act synergistically to cause unusual or poorly described symptoms. An individual may have unusual genetic susceptibility to an agent. Finally, there may be a long latency period between exposure and the development of symptoms causing the physician and patient to overlook chemical vectors of illness.

Current occupational health practices in Arkansas

A recent workplace health survey[7] was mailed to a sample population of 500 companies selected from The Arkansas Directory of Manufacturers to determine the presence and content of employee health services (EHS). Fifty-six percent of the 75 respondents reported having employee health services. Large companies more frequently have programs. Most services are directed by safety personnel (36%), registered nurses (24%), licensed practical nurses (24%), or company employees with no special training (10%). Physicians directed only seven percent of the programs. Most companies indicated a need for educational programs in areas relevant to occupational health including emergency management of injury.

Occupational/environmental practice

Developing a program

Planning a total program in occupational and environmental health for an industry may involve early consultation with management. Consideration of ethical issues must remain in the forefront. In addition there are an abundance of regulations by various agencies which must be considered. Physicians who take over responsibility for an existing occupational health program should do so only after a careful review of policy.

Preplacement Examinations

The value of a pre-placement examination must be viewed critically. Without an understanding of the requirements of a job such an evaluation may be futile. Some routine procedures, such as pre-employment back x-rays are of little benefit for the worker or his employer. In order to protect confidentiality, records of medical examinations should be retained by the physician or clinic. The employer should only receive necessary information about restrictions that the patient may require.

Drug screening in the workplace

Few issues in occupational medicine are as controversial at the present time as drug screening programs. Current testing procedures are inexpensive and highly accurate. Such testing is fostered by the federal government as a means of limiting the market demand in the "war on drugs" and employers hope to achieve worksite safety and improve job performance. A recent survey[7] indicated that employers in Arkansas rank this as their leading health issue. Legal and ethical issues abound. Careful consideration of policy with knowledgeable experts is important prior to the institution of such a program. A number of excellent reviews of this delicate subject are available.[8-11]

Screening and health promotion programs

Many companies which value the health of their workers conduct screening programs for common medical problems, e.g., diabetes, hypertension, and elevation of cholesterol. Some are engaged in health promotion programs like the use of computerized health risk appraisal, smoking cessation and exercise programs. Such programs are frequently developed by employee groups, the company nurse, or entrepreneurs and sold to company management.

Employee Assistance Programs (EAP)

These programs were developed decades ago by large industry to help with problems from alcohol abuse among employees. Their role has expanded to include counselling for personal and financial problems which interfere with work performance. Private counselling firms frequently contract with industries to provide these services.

Surveillance Programs

Periodic examinations may be required by regulatory agencies for certain types of workers (for example, truck-drivers, pilots, workers with exposure to asbestos, ethylene oxide, etc). It is important to review guidelines by recognized authorities when providing such examination.

Workers' Compensation

Work-related health problems may be managed at the jobsite, but in Arkansas most are referred to primary care providers. Industry or their insurance carriers spend the greatest amount of money each year in this area. There are many systems of worker's compensation and each may have unique rules for their program, but physicians generally receive no training about these areas. Instead they learn by their experiences or guess about the rules governing the definitions of work-related injury and illness and other limitations of the system. As a result, complaints are voiced by worker's compensation officials and representatives of insurance carriers, who find it difficult to obtain timely and consistent information about injuries from some physicians. Doctors have their own objections about paperwork and claim denials.

Evaluation of chemical exposure

Physicians involved in occupational medicine are frequently asked by patients if chemicals in the workplace are related to their symptoms. It is widely known that any substance can be toxic, depending on the dose. The essentials of diagnosis of chemically-induced disease or injury are similar to the diagnosis of disease from other vectors. The physician must obtain the history of symptoms and exposure, with attention to factors which might alter individual sensitivity or the intensity of exposure. It is important to determine if an appropriate temporal relationship exists between exposure and illness. Known information about the chemical's effects must be reviewed. Alternative explanations for the patient's problems must also be considered. If appropriate laboratory tests exist which help to confirm the diagnosis, such studies should be obtained. The strength of association between exposure and injury can be weakened if any of these steps are abbreviated or omitted.

Tracking

The injured employee may become "lost" in the medical care system from the standpoint of management. Tracking is an important feature of a contemporary occupational health service. A "tracking" program will keep up with the status of the worker's impairment and make information available to the employer on a regular basis. Rehabilitation is the ultimate goal, and a systematic approach must be incorporated into a total program.

Teamwork

The physician involved in occupational medicine will frequently interact with workers involved in industrial hygiene, safety, and toxicology support personnel. He may direct studies using epidemiologic techniques to provide the employer with answers to questions regarding causation. He may also be asked to plan or direct health or first aid training programs for company employees.

Educational opportunities

There have been few opportunities for physicians to obtain training in occupational medicine in this state. There are no approved residencies in Arkansas and extremely few physicians have had training in this area. Occupational Medicine "mini-residencies" are intensive training programs which provide physicians with a broad review of issues in the field. Such programs are available in several states. Few continuing education programs in Arkansas have addressed specific issues relevant to occupational medicine.

Occupational health nursing

The content of material included in curricula of baccalaureate programs in the state has been reviewed by a telephone survey. It indicated a need to expand the occupational health material in all of the state's nursing programs in order to prepare students for involvement in this field.[12] There are essentially no occupational health nursing updates in Arkansas. *[Editor's Note: There will be an article in the December issue of the* **Journal** *by the authors concerning the Role of the Occupational Health Nurse.]*

Other programs

The medical school offers graduate training in the field of toxicology. Both Master of Science and Doctor of Philosophy degrees are granted. There are currently no programs in the state for advanced training in industrial hygiene, although a number of seminars are held by universities. The Division of Clinical Toxicology at the University of Arkansas for Medical Sciences, in conjunction with the University of Arkansas at Little Rock has recently received approval for a program which will grant a Master of Sciences degree in occupational and environmental health.

There have been few opportunities for physicians to obtain training in occupational medicine in this state. There are no approved residencies in Arkansas and extremely few physicians have had training in this area.

Summary

Nurses, safety officials, or management are in charge of occupational and environmental health issues in most Arkansas companies. Nurses are not well-prepared for the typical responsibilities of such a position. It is rare for a physician to assist in the development or management of a company's employee health service.

Patients with significant acute injury or illness rely upon a primary care physician in an office or emergency department for treatment. It is unusual for a physician to have specific training in occupational illness, but workplace injury is easily recognized and constitutes a large part of primary care practice. Few employees have jobsite access to health care by a physician. Companies commonly designate a physician to see their "workers compensation" cases, which are almost always related to injury rather than illness.

There has been little opportunity for physicians to receive training in the area of occupational health in this state while in medical school or as housestaff, and few continuing education programs specifically address work-related problems.

Expanded government regulations and enhanced news coverage of environmental problems have made today's patients more aware of the possibility of illness following exposure to chemicals from the workplace or environment.

Recommendations

Physicians in primary care deserve an opportunity for additional training in the recognition and prevention of occupational health problems. Continuing education programs for physicians in these specialties should include current information on occupational illness as well as injury.

Patients are concerned about chemical exposure from many sources. Much of the concern has little basis in fact, but the patients deserve recommendations based on scientific information. A central source is needed in Arkansas to disseminate data about the health effects of specific chemicals to workers, physicians, or other interested parties, and to assist physicians in the identification of chemically-related health problems. Such a program could be provided by an expanded poison control system, or it could be a responsibility assigned to the health department, as has been done in other states.[13]

Acknowledgements

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Medicine in the News

History of Medicine Videotape Project

At its last board meeting the History of Medicine Associates named a Videotape Project Committee. Members of the Committee are Drs. Ray Jouett, Horace Marvin, Art Martin, and Payton Kolb. The purpose of the project is to videotape interviews with some Arkansas senior physicians so that some of the changes in practice will be documented and preserved. The first interview has been taped with Dr. Gilbert Dean of Little Rock. If you have suggestions of persons to be interviewed, please let a member of the committee know.

The Videotape Project has received funding from the Council of the Arkansas Medical Society, the Arkansas Society of pathologists and from the Medical Education Foundation for Arkansas for a total budget of $5,000.

The Malpractice Suite: Survival Manual Available

A new video, The Malpractice Suit: A Survival™ Guide for Physicians and Their Families, recently became available through Eidetics, Inc. The video is edited by Graham Chedd, Andrew Liebman, and Alice Markowitz with Frederick Gale, Robert Pearlstein, and James Kirk and was recently reviewed in the *New England Journal of Medicine*. In the review, the author, Barry M. Manuel, M.D., writes, " This video is a professionally executed documentary that provides a total perspective on the malpractice suit. Its purpose is to inform physicians about the litigation process, its emotional impact on the physician and his or her family, and the prerequisites for surviving a lawsuit either through settlement or in court."

Physicians who had been sued were interviewed and talk about their experiences. Dr. Manual cites that the video makes several points about litigation and its effects on the physicians. He concludes his review by writing, "I strongly recommend this video not only for physicians who have been named in a malpractice suit but also `prophylactially' for all physicians practicing medicine in our litigious society."

The video runs 68 minutes and includes a 123-page book with it. It comes in VHS, BETA and 3/4" U-Matic. Each tape is $295 ($345 for U-Matic) and orders can be placed by writing or calling Edietics, Inc., 80 Coolidge Hill Road, Watertown, MA, 02172, (617) 926-9226.

Insurance Company to Pay for AZT

John Alden Life is the first insurance company to announce that it will follow the National Institute of Allergy and Infectious Disease's (NIAID) recommendations for zidovudine (AZT) intervention in early symptomatic HIV infection in Alden's Patient Advocacy Program. All of the company's insureds who have symptomatic HIV infection with a T4 cell count less than 500 can have their AZT prescription reimbursed. Insureds will have to enroll in the Patient Advocacy Program and order their AZT through Family Pharmaceuticals of Mt. Pleasant, South Carolina.

John Alden Life's decision to base its reimbursement policy on NIAID's clinical trial data reinforces FDA Commissioner Frank Young's position that third-party payors should not base reimbursement policies on FDA labeling which is designed for the marketing of the drug and not intended to be the standard of whether a drug was or was not investigational or appropriate treatment.

In announcing the new policy, Larry Cumbie, the company's Vice President of the Southern Customer Division, stated, "I hope that our public statement will encourage more of our insureds at risk for HIV infection to be tested and, if positive, seek early medical intervention." When questioned about the additional cost to the company for the AZT prescriptions, Mr. Cumbie replied, "Our decision was based on the clinical data and not on the cost of the drug. The evidence will most likely result in a FDA label change for AZT and those companies who based their reimbursement on label indications will eventually have to pay for it. That's what happened with aerosol pentamidine. We approved reimbursement for aerosol pentamidine in January of 1988 and the FDA guidelines came out eighteen months later. We hope that our early action was a factor in preventing PCP (Pneumocystic carinii pneumonia) in some of our insureds."

Health IRA Concept Being Embraced

The Health IRA concept that AMA has fostered is being embraced as one feature of an "IRA-plus" proposal introduced by Sen. William Roth (R-DE), ranking Republican on the Joint Economic Committee. Intent of the Roth plan and others similar to it that are now being explored by the Bush Administration and several Senators is to stimulate greater individual savings. Economists are concerned about the nation's low level of private savings (about 5.5%) which is one of the lowest among industrialized nations. Under Roth's bill withdrawals from the new type of IRA would be tax free for those who are retired. Other would be permitted to withdraw up to 25% of their IRA investments without penalty for three specific purposes - paying off large medical expenses, buying a home or financing educational expenses. Contributions, however, would not be tax deductible as they are now for individuals in lower tax brackets. Individuals who already

have IRAs would be able to convert them to "IRA-Plus" accounts. Individuals having annual incomes of less than $25,000 would receive tax credits based on 25% of their contributions.

Establishing Health IRAs is one of the components of AMA's Medicare reform proposal, H.R. 2600, which was reintroduced in the new Congress by Rep. Charles Rose (D-NC). That proposal (which was H.R. 4455 in the last Congress) is based on AMA Board of Trustees Report MM which was adopted by AMA's House of Delegates at the 1986 annual meeting as a new approach for financing health care of the elderly. Under H.R. 2600 individuals with supplemental tax-exempt IRAs could make tax-free withdrawals for medical expenses upon reaching medicare eligibility age. Other components of the proposal include replacing the present Medicare program with a system of vouchers so that individuals could purchase private health insurance of their choice; financing these vouchers through a tax on adjusted gross income during working years and continuing the current employer health insurance payroll tax; establishing tax rates at a level sufficient to pay for current Medicare beneficiaries; and to preserve all tax contributions of the future use of those taxed. The plan also calls for increased cost-sharing among the financially well-to-do elderly.

Licensure Book Available

If you are planning to start or move your practice the newest edition of U.S. Medical Licensure Statistics and Current Licensure Requirements is the only single source containing information on medical licensure requirements for every state i the U.S.

The new edition includes information State Board licensing policies as of December 1988, requirements for FLEX and FMGEMS examination, reciprocity/endorsement policies, fees, renewal intervals and CME requirements, national board and ECFMG requirements, details on the new Special Purpose Examination (SPEX) and the current guidance for licensure for the Department of Defense.

The book is available to AMA members for $28.00 and non-members for $35.00. For further information about the book, call 1 (800) 621-8335.

Grateful Med Available for Macs

The National Library of Medicine's Grateful Med software is now available for use on any of the Apple family of Macintosh personal computers. Grateful Med was introduced in 1986 for IBM-compatible PC's as a way for individual health professionals to have immediate, easy, and economical access to MEDLINE and other NLM databases.

More than 11 million records are on-line for searching: references and abstracts to medical journal articles; catalog data on books, monographs, and audiovisual materials using in the health sciences; specialized information about drugs, chemicals, hazardous waste materials, data on toxic releases into the environment; and databases with information about cancer and AIDS.

Grateful Med allows health professionals and others to have direct access to this information from personal computers. The system is menu-driven and complete automates the chores of making telephone connection to the NLM computer in Bethesda, logging on the system, entering the search terms, and downloading retrieved records to the user's microcomputer. The average cost of a search via Grateful Med is about $3.

Requirements for the Mac are 512Kb, one floppy disc, Hayes-compatible modem. Annual updates are issued at no charge.

Grateful Med software is available from the National Technical Information Service, 5285 Port Royal Rd., Springfield, VA 22161. The cost is $29.95 plus $3 handling. For more information contact the National Technical Information Service.

ICD-9-CM Coding Errors Found

Physicians need to check for errors on the preprinted lists of diagnosis codes provided by superbill printers and computer companies, according to Margaret Skurka, a national coding expert.

Skurka found an average 25% error rate on the lists of diagnosis codes and terminology she's reviewed for 50 private practitioners in over 12 specialties.

Most often made mistakes include not coding to the greatest level of specificity, using a three digit code when the classification has a fourth or fifth digit requirement. Failing to code for both the etiology and manifestation of disease, and substituting in-house terms for official nomenclature are other common mistakes.

Skurka, an associate professor at Indiana University Northwest in the Medical Record Technology Program has also taught coding for state hospital associations. To help physicians access accurate diagnosis code, Skurka developed 11 condensed specialty-specific ICD-9-CM guides, called "Code Its." Listings are available for family practice, cardiology, ENT, OB/GYN, pediatrics, cardiovascular surgery, ophthalmology, urology and podiatry. Each laminated "Code Its" contains over 140 accurate diagnosis codes broken into easy to reference categories. "Code Its" are sold in sets of two for $25. For further information about "Code Its" contact Karen Zupko & Associates, 980 North Michigan Avenue, Suite 1360, Chicago, IL 60611.

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Things To Come

November 26 - December 1

75th Scientific Assembly and Annual Meeting of the Radiological Society of North America. Presented and sponsored by RSNA. McCormick Place, Chicago, IL. For further information, contact Carolyn Mills, RSNA at (312) 558-1770.

November 30 - December 1

Improving Quality in Long Term Care. Presented by the Joint Commission on Accreditation of Healthcare Organizations and the American Geriatrics Society. Westin Hotel, Chicago, IL. Nine Category I credit hours; 11.7 CEUs. Fee: $390. Further information: JCAHO, Department of Education Programs, 875 North Michigan Avenue, Chicago, IL 60611; (312) 649-8023.

November 30-December 1

Fourteenth Assembly Meeting, Hospital Medical Staff Section, AMA. Keynote speaker, James O. Mason, M.D., Dr.P.H., Assistant Secretary for Health, Department of Health and Human Services. Sponsored by the AMA. Sheraton Waikiki Hotel, Honolulu, HI. For further information call (312) 645-5450.

December 1-3

Medical Staff Issues. Presented by Joint Commission on Accreditation of Healthcare Organizations physician consultant. Sponsored by Florida Hospital Association and co-sponsored by the Alabama and Georgia Hospital Associations. Hyatt Regency Grand Cypress, Orlando, FL. Eleven Category I credit hours. Fee: $445. For further information call the Florida Hospital Association, (407) 841-6230, ext. 400.

December 7-8

Program of Hospital Accreditation Standards (PHAS) '89. Sponsored by Joan M. Paquin, Director of Education Services, Virginia Hospital Research and Education Foundation. Further information, (804) 965-1213.

December 8-9

Physicians, Family and Addictions. Presented and sponsored by the Medical Society of Virginia Health and Effectiveness Program. Royce Hotel, Williamsburg, Virginia. Further information: Jeanne N. Douglas, 1 (804) 353-2721.

December 8-10

Medical Staff Issues. Presented by Joint Commission on Accreditation of Healthcare Organizations physician consultant. Sponsored by the Education Department of California Association of Hospitals and Health Systems. Sacramento, CA. For further information call (916) 443-7401

December 15-17

Pediatric Update. Presented by Betsy Busch, M.D.; Dennis L. Christie, M.D.; Gerald W. Fischer, M.D.; Gerald B. Merenstein, M.D.; Richard J. Whitley, M.D.; and Errol R. Alden, M.D. Sponsored by the American Academy of Pediatrics. Williamsburg Lodge and Conference Center, Williamsburg, VA. Sixteen Category I credit hours. Fees: AAP Resident or Candidate Fellow or Allied Health Professional, $220; AAP Fellow, $300; Nonmember, $365. Further information: 1 (800) 433-9016.

January 4-7

Current Concepts in Pediatrics. Presented by Marion Howard, Ph.D., (Adolescence); Laurie J. Smith, M.D. (Allergy); and James D. Cherry, M.D., Mary P. Glode, M.D., Russell W. Steele, M.D. (Infectious Diseases). Sponsored by the American Academy of Pediatrics. Vail, Colorado. Sixteen Category I credit hours. Fees: AAP Resident Fellow, Candidate Fellow and Allied Health Professionals, $220; AAP Fellow, $300; Nonmember Physician, $365. Further information call 1 (800) 433-9016 and ask for CME Registration.

February 1990

31st Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. Sponsored and presented by the Johns Hopkins University School of Medicine. February - April 1990: Home Study Course A is provided for personal reading and microscopic study in own laboratory in preparation for Course B. April 23 - May 4: In-Residence Course B is an extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore, MD. One hundred and fifty-two Category I credit hours. Registration must be complete before January 1, 1990. For further information contact, John K. Frost, M.D., or Ms. Betty Ann Remley, 111 Pathology Building, Johns Hopkins Hospital, Baltimore, MD 21205; (301) 955-8594.

KEEPING UP

Chronic Obstructive Lung Disease

November 28, 12:00 noon. Presented by Stephen G. Jenkinson, M.D., San Antonio, TX. Sponsored by St. Vincent Infirmary Medical Center. Conference Room 1, St. Vincent Infirmary Medical Center.

Septic Shock

November 28, 12:00 noon. Presented by Russell Steele, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Pediatric Cardiology

November 29, 12:00 noon. Presented by Arkansas Children's Hospital cardiologist. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Pathogens in Respiratory Infections

November 30, 7:00 p.m. Presented by Terry Yamauchi, UAMS, Little Rock. Sponsored by UAMS, AHEC Southwest. Special Events on the Boulevard, 2101 Texas Boulevard, Texarkana, TX.

Treatment of Acute MI

November 30, 12:00 noon. Presented by Jose Perez, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Recurrent Pneumonia in Children

December 6, 12:30 p.m. Presented by Louay Nassri, M.D. Sponsored by AHEC Fort Smith. Medical Library, Sparks Regional Medical Center.

Acute Care of the Critically Ill Child

December 7 - 9, times to be announced. This course is a more intensive version of the October offering. Sponsored by Arkansas Children's Hospital. Further information: Blanche Moore, Arkansas Children's Hospital, 800 Marshall Street, Little Rock, AR 72202, 370-1481.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Building Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, Sturgis Building, Room 121
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Second Floor Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, Sturgis Building, Rooms S120-121
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

AIDS Conference, second Friday, 12:00 noon, Location to be announced. Sandwich buffet.
CARTI Cancer Conference, first Wednesday, 12:00 noon, CARTI Auditorium. A meal is provided.

Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell Room. A meal is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. A meal is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Arkla Room. Refreshments are provided.
Internal Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. A meal is provided.
Pediatric Conference, first Tuesday, 12:30 p.m., LaHarpe de Paul Room. A meal is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, fourth Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS Education Building, Room G137, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 7:30 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Fundamental Sciences Conference, first Tuesday, 6:00 p.m., UAMS Chancellor's Area, Conference Room B-2
Surgery Grand Rounds, one Saturday per month, 8:00 a.m., UAMS Education Building, Room G/141A, 1.5 credit hours
Surgery Morbidity and Mortality Conference, Wednesdays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Resident Case Conference, Mondays, 5:00 p.m., UAMS Education Building, Room G/141A
Surgery Review Conference, Mondays, 6:00 p.m., UAMS Education Building, Room G/141A
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Conference (Pediatric), once monthly, 5:00 p.m., Arkansas Children's Hospital, Sturgis Building, Clinic 2
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Tuesdays, 5:00 p.m., UAMS Education Building, Room G/131A&B

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

MAKE PLANS NOW TO ATTEND THE 1990 ARKANSAS MEDICAL SOCIETY ANNUAL MEETING, MAY 3 - 5, 1990 HOT SPRINGS ARLINGTON HOTEL

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MANUSCRIPT STYLE

The first page should list titles, degrees, and any hospital or university appointments of the author(s). Manuscripts should be typewritten, double-spaced, and have generous margins. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

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References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the authors(s) for the complete list. References must contain, in the order given: Name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text.

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AMS NewsMakers

AMS Staff Trained in CPR

We are pleased to report that AMS staff members recently completed (with flying colors!) the basic requirements for certification in Cardio-Pulmonary Resusitation (CPR). The staff was instructed by two third-year medical students, Sherilyn Webb and Carla Scott, who did an excellent job of preparing the class for the written and the demonstration examinations. Staff members who are now certified are: **Ken LaMastus, Lynn Zeno, David Wroten, Peggy Pryor Cryer, Judy Donaldson, Laura Harrison, Teresa Sidebottom, and Martha Taylor.** Also passing the course was **Susan Rish**, Assistant Program Director for the Arkansas Health Care Access Foundation. All the participants want to thank Ms. Webb and Ms. Scott for taking the time from their busy schedules to instruct the group.



AMS CPR class: (first row, left to right) Pat Stiles, a family member participant, Annie (our willing victim), Judy Donaldson, Teresa Sidebottom, Susan Rish; (second row, left to right) Ken LaMastus, Laura Harrison, Martha Taylor; (back row, left to right) Carla Scott, instructor; Jim Sidebottom, family member; David Wroten, Peggy Pryor Cryer, Carrie Wroten, family member; Sherilyn Webb, instructor; and Lynn Zeno (and friend).

Russell Pang, M.D., a Fayetteville psychiatrist, has been named the service director of the adult psychiatric program at the Charter Vista Hospital in Fayetteville. Pang has been associated with the hospital for several years.

St. Paul Companies, Inc. Present Check

The General Manager for the St. Paul Companics, Inc., **Mr. Nicholas Nelson**, recently presented a check for over $26,000 to the Physicians Health Committee Chairman, **J. L. Martindale, M.D.** The check represents the dividends made available to St. Paul physician insureds for 1986. Physicians were given the option to receive the dividend (an average of $18 per physician) or to have it contributed to the Physicians Health Committee.

The funds will be used for the work the Physicians Health Committee does helping drug and alcohol impaired physicans in the state of Arkansas.



Mr. Nicholas Nelson, General Manager for St. Paul Companies, Inc., presents the check for over $26,000 to J. L.. Martindale, M.D., Chairman of the AMS Physicians Health Committee as Mr. Tom Hesselbien, Medical Services Division Manager for St. Paul looks on.

The Northwest Arkansas Radiation Therapy Institute (NARTI) recently elected **Jan Turley, M.D.**, as the chairman of the NARTI Physician Advisory Board. Turley is a urologist in Rogers.

Jerry Chapman, M.D., a family physician in Cabot, has been named a Fellow of the American Academy of Family Physicians.

The Marianna/Lee County Chamber of Commerce recently heard **Maurice Elovitz, M.D.**, a general surgeon from Helena, speak about AIDS and its influence on communities throughout Arkansas.

James Mashburn, M.D., a retired Fayetteville physician, was honored at a reception marking the official establishment of the James Mashburn Scholarship Endowment Fund. The fund was organized to recognize Mashburn for his community service and achievements and the monies will be used to assist health care students planning to serve in Northwest Arkansas after graduation. Mashburn has practiced for 38 years in the Fayetteville area.

The American Heart Association Arkansas Affiliate, Inc. named its board of directors for the coming year and several AMS physicians were elected. The doctors elected were: **Randy Jordan**, Little Rock; **Tommy Love**, Little Rock; **Taylor Prewitt**, Fort Smith; **John T. St. Clair**, Jonesboro; **J. Trent Beaton**, Wynne; **David Bauman**, Little Rock; **James K. Cornett**, Little Rock; **Milton E. Deneke**, West Memphis; and **John Henderson**, Searcy.

The American Medical Association recently named the Arkansas recipients for the Physician Recognition Awards (PRA) for 1989. The PRA recognizes physicians who have voluntarily completed 150 hours of continuing medical education during a consecutive three-year period. The Arkansas physicians receiving the award are: **Robert V. Baker**, Batesville; **Glen V. Dalrymple**, Little Rock; **Craig A. Ferris**, Russellville; **Paul M. Fiser**, Little Rock; **David B. Fraser**, El Dorado; **Edward P. Hammons**, Forrest City; **Morris M. Henry**, Fayetteville; **Paul J. Hergenroeder**, Newport; **Diane G. Lepore**, Jonesboro; **Sara E. McBee**, Fayetteville; **James E. McDonald**, Little Rock, **Joseph S. Murphy**, Little Rock, **Kenneth E. Murphy**, Conway; **James J. Pappas**, Little Rock, **Cal R. Sanders**, Camden; **John E. Slayden**, Little Rock; **Aubrey C. Smith**, Little Rock; **John M. Stair**, North Little Rock; **Harold P. Stern**, Little Rock; **Edwin Whiteside**, Fort Smith; **Alonzo D. Williams**, Little Rock; and **Douglas E. Young**, Little Rock.

J. David Busby, M.D., the Executive Vice President for Medical Affairs of the Arkansas Foundation for Medical Care, Inc., was elected Vice President of the American Medical Peer Review Association (AMPRA) at the recent House of Delegates meeting of AMPRA. Busby has been with the AFMC since 1985.

EASTERN ARKANSAS - Established Internist in community of 14,000 seeks associate in thriving practice. 120-bed JCAHO hospital with ICU and excellent medical staff. Office space and attractive financial package available. Contact Jeff Hartline, Search Consultant, 5000 Linbar Drive, Suite 260, Nashville, TN 37211, 800/678-3616.

Memorials honoring Arkansas Medical Society members and their spouses can be made to the Medical Education Foundation for Arkansas (MEFFA), Post Office Box 5776, Little Rock, AR 72215. Call the Society for information.

TAKE THE FIRST STEP TO RECOVERY

The Physicians Health Committee exists for you, the physician who is struggling with drug or alcohol addiction. The committee is composed primarily of physicians who have ''been there'' and want only to help their colleagues from making the same mistakes.

The Committee members are willing to set up interventions, recommend treatment, and help with aftercare and re-entry.

The Committee is not involved in any legal, moral or punitive judgements.

ON CALL FOR YOU

Don't throw away your profession because of drugs and alcohol. Contact our Physicians Confidential Assistance Hotline at (501) 370-8221. Only specially trained personnel will return your call. Or contact the Arkansas Medical Society office at (501) 224-8967 or 1-800-542-1058 and ask for the name of one of the Physicians Health Committee members.

All inquiries are confidential within the Committee and no names or locations are necessary when contacting the Society office.



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New Members

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Adams, Frank Garrison (D.O.), Family Practice, Bentonville. Born August 19, 1952; Oklahoma City, OK. Pre-medical education Central State University, OK, B.S., 1976. Medical education, Texas College of Osteopathic Medicine, Fort Worth, D.O., 1985. Internship, Doctors Hospital of Stark County, Massillon, OH. Residency, Barberton Citizens Hospital, Barberton, OH. Practice experience, 1 year, Claremore, OK; 1 year, Bentonville. Board certified, Family Practice.

Hernsberger, III, H. Graves, Otolaryngology, Rogers. Born September 18, 1958, Camden, AR. Pre-medical education, Southwestern University, Memphis, TN, B.S., 1980. Medical education, University of Arkansas for Medical Sciences, 1984. Internship, Brackenridge Hospital, Austin, TX. Residency, UAMS. Board eligible. Member, American Academy Facial Plastic and Reconstructive Surgery, American College of Surgeons.

Jefferson County

Anderson, Daphne, Dermatology, Pine Bluff. Born February 4, 1958, Jennings, LA. Pre-medical education, Centenary College, Louisiana, B.S., 1979. Medical education, Tulane University, New Orleans, 1983. Internship/residency, University of Missouri, Columbia. Practice experience, 2 years, Columbia, MO. Board certified, Dermatology.

Phillips County

Duensing, Ted W. (D.O.), General Surgery, Helena. Born January 23, 1956, Tulsa, OK. Pre-medical education, University of Tulsa, 1979. Medical education, Oklahoma State University College of Osteopathic Medicine, 1982. Internship/residency, Oklahoma Osteopathic Hospital, Tulsa. Practice experience, 4 years, Tulsa; 2 years, Helena. Appointed Chief of Surgery, Helena Regional Medical Center, 1989. Board certified. Member, American College of Osteopathic Surgeons.

Pulaski County

Eisner, Richard A., Ophthalmology, Little Rock. Born June 8, 1954, Pittsburgh, PA. Pre-medical education, University of Texas, Lubbock, B.S., 1976. Medical education, Texas Tech Health Sciences Center, Lubbock, 1982. Internship, Texas Tech University. Residency, University of Arkansas for Medical Sciences. Board eligible.

Teplick, Steven K., Radiology, Little Rock. Born May 202, 1943, Philadelphia, PA. Pre-medical education, University of Vermont, B.A., 1963. Medical education, Hahnemann Medical College, 1976. Internship, Maimonides Medical Center, Brooklyn, NY. Residency, Boston City Hospital, Boston, MA. Practice experience, Philadelphia, PA; Boston, MA: and Tripler Army medical Center. Board certified, Radiology.

Baker, Yvette K., Neurology, Little Rock. Born December 19, 1958, Los Angeles, CA. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1981. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, UAMS. Board eligible, neurology.

Fazekas-May, Mary A., Otolaryngology, Little Rock. Born April 2, 1956, Louisiana. Pre-medical education, Louisiana State University, Baton Rouge, B.S., 1978. Medical education, Louisiana State University, New Orleans, 1982. Internship/residency, LSU, New Orleans. Practice experience, 2 years, Little Rock. Board certified, otolaryngology.

Student Section

Nutt, Angela K., Freshman

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In Memoriam

James W. Durham, M.D.

James W. Durham, M.D., a retired family practitioner, died September 14, 1989. He was 61.

Dr. Durham graduated in 1953 from the University of Arkansas for Medical Sciences and practiced family medicine in Jacksonville for 33 years. He was a member of the national, state, and county medical associations as well as the American Academy of Family Practice. Dr. Durham was a member of the AMS Special Committee on AIDS. He also was a past president of the Jacksonville Sertoma Club.

Dr. Durham is survived by his wife, Eliose Durham; three sons, James M. Durham, David W. Durham, all of Jacksonville, and Dan A. Durham of Memphis; his mother, Margurite Harper Durham; a sister; Mrs. Carol O'Dell, both of Jacksonville and one grandchild.

Monroe B. Painter, M.D.

Monroe B. Painter, age 55, of Fayetteville, died Sunday, September 24, 1989.

Dr. Painter was the former chief of staff at Fayetteville City Hospital and Washington Regional Medical Center. He was a past president of the American Society of Internal Medicine, a Fellow in the American College of Physicians, and a board member of the First National Bank of Fayetteville. Dr. Painter was a member of the American Medical Association as well as the state and county medical societies.

Dr. Painter is survived by his wife, Louise Wilkerson Painter; a son, Hugh Allen Painter of Miami; two daughters, Susan Keen of Fayetteville and Mary Beth Painter of Little Rock; three brothers, James A. Painter of Green Valley, AZ; Charlie L. Painter, Jr., of Phoenix; and Hugh Y. Painter of Liberty, MO; two sisters, Jean Leech of Fayetteville, MO and Louise Smith of Rolla, MO; and two grandchildren.

Jack W. Kennedy, M.D.,

Jack W. Kennedy, M.D, a Life Member and Past President of the Arkansas Medical Society, died October 11, 1989. He was 80.

Dr. Kennedy graduated from the University of Arkansas for Medical Sciences in 1940. He was a former health officer for Clark County Health Office and a member of the Arkansas Rotary Club and served on the board of his church. He was a World War II Army veteran.

Dr. Kennedy is survived by an aunt, Della Elder of Mt. Ida; and two cousins, June Gray of Kansas City, MO, and Rith Oster of Fort Worth, TX.

Resolution

James William Durham, M.D.

Whereas, the membership of the Pulaski County Medical Society notes with sincere sorrow the recent death of our colleague, James William Durham, M.D., and

Whereas, Dr. Durham was a devoted member of this Society for twenty-seven years, and

Whereas, his deep concern for the care of his patients and for the betterment of society at large was widely known, and

Whereas, his interest in the affairs of this Society was clearly indicated by the many contributions he made to its betterment, be it therefore

RESOLVED, that this resolution be adopted and made a part of the permanent records of this Society; and

RESOLVED, that a copy of this resolution be forwarded to Dr. Durham's family as an expression of our sincere sympathy; and

RESOLVED, that a copy be forwarded to the Arkansas Medical Society for publication.

Adopted
Executive Committee
October 18, 1989

By Order of the Memorials Committee
Marlon Doucet, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

Gene Girkin, M.D.
President

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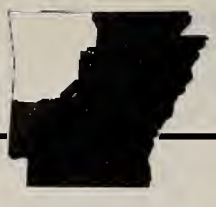
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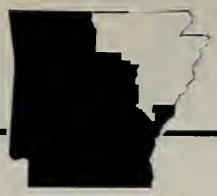
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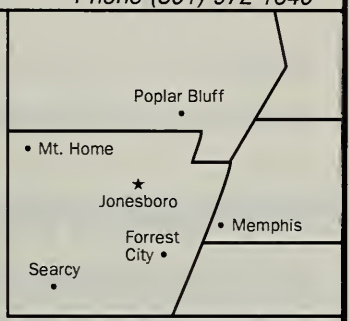
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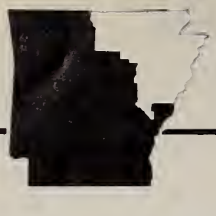
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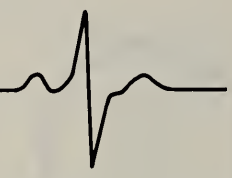
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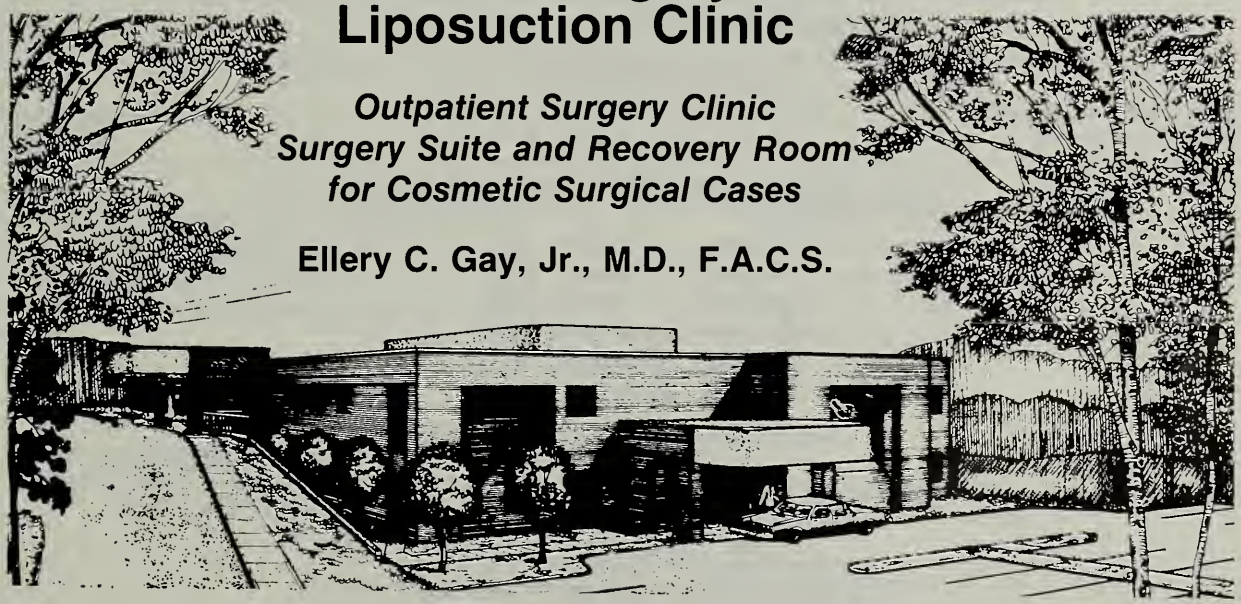
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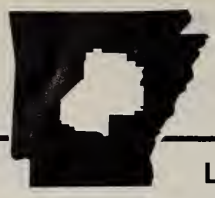
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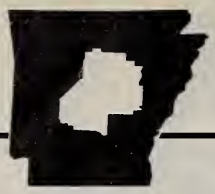
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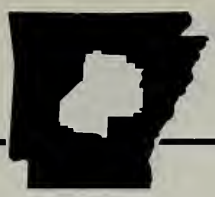
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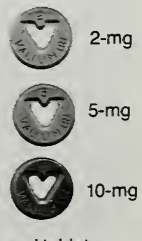
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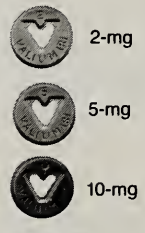
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On Our Cover: "The Old Mill" in North Little Rock. The photographer is Harold Clowers, an employee at the Family Medical Clinic, Ltd. in Little Rock.

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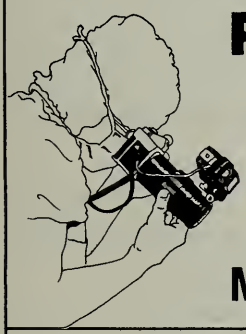
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To the Members of the Arkansas Medical Society:

We published an advertisement which appeared in the Arkansas Medical Society's 1989-90 "Directory of Members" and the July and August, 1989 issues of the "Journal of the Arkansas Medical Society." The advertisement contained a table comparing attributes of State Volunteer Mutual Insurance Company (SVMIC) and its Medical Professional Insurance Policy with those of three other companies doing business in Arkansas.

It has been brought to our attention that the wording of two of the points of comparison may have been unintentionally misleading or confusing to readers of the advertisement. We believe that an explanation is in order and offer the following clarification.

We stated, with reference to SVMIC, that "Only Physicians [are] Eligible for Dividends," a feature that did not apply to The St. Paul. We acknowledge that The St. Paul has a plan entitled "Retrospective Premium Plan" which operates essentially the same as a dividend plan for Arkansas physicians. The St. Paul, as a stock corporation owned by public investors, also pays substantial dividends to non-physician stockholders in addition to payments to physicians. The distinction we wanted to make was that SVMIC has no non-physician owners and credits 100% of its dividends exclusively to physician policyholders. We did not intend for you to conclude that The St. Paul does not have a plan similar to a dividend plan for Arkansas physicians.

The advertisement also said that only SVMIC provides "Explicit Coverage in Policy for Peer Review Services." The St. Paul policy covers:

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Our use of the word "explicit" (meaning "expressed" as distinguished from "implied") with respect to our peer review coverage may not have been clear enough. The St. Paul contends that our advertisement was unfair because it failed to acknowledge what their policy does cover. We offer the above quotations from the two policies so you can be clearly informed about what the policies cover.

We regret any confusion that may have occurred as a result of our advertisement. Arkansas physicians are entitled to know the facts. We hope this letter clarifies the wording of the advertisement and the information the advertisement was intended to convey.

STATE VOLUNTEER MUTUAL INSURANCE COMPANY

AMS Special Committee on AIDS

William N. Jones, M.D., Chairman

Update December 1989: Results of Controlled Clinical Trials of Zidovudine in Early HIV Infection*

Recently the National Institute of Allergy and Infectious Diseases announced information about clinical trials of zidovudine (AZT) in HIV-infected individuals. These studies have been conducted by NIAID's AIDS Clinical Trials Group. At this time, NIAID is making no recommendation to physicians regarding clinical practice. However, the Institute plans to convene a consensus conference in the near future to develop recommendations based on the results of these studies. Meanwhile, NIAID wishes health-care practitioners to have additional information on these studies while publications are being readied for submission to peer-reviewed medical journals.

Protocol 019: Placebo-Controlled Trial in Asymptomatic HIV-Infected Persons

One study (Protocol 019), which enrolled more than 3,200 asymptomatic HIV-infected volunteers, began approximately 2 years ago. The study has three arms comparing high-dose zidovudine (300 mg every 4 hours while awake, i.e., 1500 mg/day), low-dose zidovudine (100 mg every 4 hours while awake, i.e., 500 mg/day) and placebo. Volunteers were divided into groups according to baseline T4 cell counts and randomized equally into the three treatment arms. The endpoints of the study were development of AIDS or advanced ARC. Followup ranged from 4 months to 2 years, with a mean duration of more than 1 year.

Data from the study were reviewed August 16, 1989, by a Data and Safety Monitoring Board (DSMB) which found that in those participants with a baseline of <500 T4 cells who received either dose of zidovudine, the rate of progression to AIDS or severe ARC was roughly half that for participants with <500 T4 cells who receive placebo. No significant differences were seen in those persons receiving 500 mg/day versus those receiving 1500 mg/day with respect to onset of AIDS or advanced ARC.

The toxicity of zidovudine in patients with advanced HIV disease is well known. In contrast, zidovudine toxicity experienced by the persons studied in Protocol 019 was minimal. More important, with the exception of nausea that occurred in about 3 percent of the volunteers, virtually no differences in side effects were observed in persons receiving the lower dose and persons receiving placebo.

On the basis of these results, the DSMB recommended that the placebo arm of the study be halted for participants with <500 T4 cells. Participants in this group have been offered zidovudine (100 mg every 4 hours while awake). The study will continue for persons with >500 T4 cells, since this study has shown that short-term risk of developing AIDS is negligible in this group. In this group, persons whose T4 counts fall below 500 will be offered zidovudine.

"These studies...show that zidovudine can delay disease progression in HIV-infected persons with<500 T4 cells."

Protocol 016: Placebo-Controlled Trial in HIV-Infected Persons with Early ARC

Protocol 016 included 713 HIV-infected persons having 200-800 baseline T4 cell counts and one or two HIV-

This article was first printed by the National Institute of Allergy and Infectious Diseases, August 29, 1989 in an AIDS Clinical Trials Alert. It was prepared by the Division of AIDS, National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, MD 20892.

associated symptoms such as oral thrush, chronic rash, or intermittent diarrhea. Participants received either placebo or 200 mg of zidovudine every 4 hours (1200 mg/day). As of July 1989, 50 of the 713 participants had progressed to advanced ARC or AIDS (the study endpoints). Of these, 36 were in the placebo arm and 14 were in the zidovudine arm. Followup ranged from 3 to 20 months, with a mean duration of 9 months.

Data from the study were reviewed August 2, 1989, by a Data and Safety Monitoring Board which found a highly significant difference in the development of advanced ARC or AIDS between the treatment and placebo groups in those persons with 200-500 baseline T4 cell counts. No clear benefit was seen in persons with baseline T4 counts of >500. Fewer than 5 percent of all study participants experienced serious side effects.

The DSMB recommended that Protocol 016 be halted. All study participants in Protocol 016 have been offered zidovudine therapy.

Conclusions

The results of these studies significantly extend the understanding of the clinical benefits of zidovudine. Prior studies showed the benefits of zidovudine therapy in persons with AIDS and advanced ARC. The findings of these two protocols indicate that HIV-infected asymptomatic persons with <500 T4 cells as well as persons with symptomatic HIV infection do not prove whether or not overall length of survival will be affected by zidovudine treatment in these groups, nor can the length of the delay in progression be accurately determined. However, these studies do show that zidovudine can delay disease progression in HIV-infected persons with<500 T4 cells.

These studies support previous recommendations that individuals at high risk of HIV infection should be tested and that those who test positive should be under the care of a physician who can monitor their immune status, particularly as measured by their T4 cell counts, and recommend appropriate treatment.

For additional information please call 1-800-TRIALS-A.

Thanks to Our Volunteers

The Arkansas Medical Society would like to thank the following physicians for volunteering their time to participate in the AIDS Education Speakers Bureau during the past few months. The physicians who generously volunteered their time are: Jim D. Acklin, James D. Armstrong, Edwin N. Barron, Jr., Joseph M. Beck, Leston E. Fitch, Donald C. Fournier, William W. Galloway, Richard L. Hayes, Max G. Haynes, Harold H. Hedges, William N. Jones, Gregory Kressee, James K. Kolb, Jr., Linda A. Markland, James E. Nolen, Samuel W. Peebles, Allan S. Pirnique, David L. Rogers, and Dowling B. Stough, III.

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AIDS IN ARKANSAS 1989
January 1 - October 26, 1989

Total number of cases reported	57
Number of deaths	28

CASES BY SEX

Male	51
Female	6

CASES BY RACE

White	41
Black	15
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	38
Homosexual & IV Drug User	5
IV Drug User	6
Hemophiliac	1
Transfusion	1
Heterosexual (Contacts)	5
NIR#	1

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	1
20 - 29	17
30 - 39	29
40 - 49	6
50 - 59	3
60 or more	1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	19
Kaposi's Sarcoma	3
Pneumocystis Carinii and Kaposi's Sarcoma	0
Other Diseases	35

AIDS IN ARKANSAS
1985 - 1989

Total number of cases reported	230
Number of deaths	144

CASES BY SEX

Male	213
Female	17

CASES BY RACE

White	176
Black	52
Other	2

CASES BY RISK GROUP

Homosexual/Bisexual	152
Homosexual & IV Drug User	27
IV Drug User	23
Hemophiliac	2
Transfusion	10
Heterosexual (Contacts)	12
NIR#	4

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	3
20 - 29	75
30 - 39	103
40 - 49	32
50 - 59	9
60 or more	8

OPPORTUNISTIC DISEASE

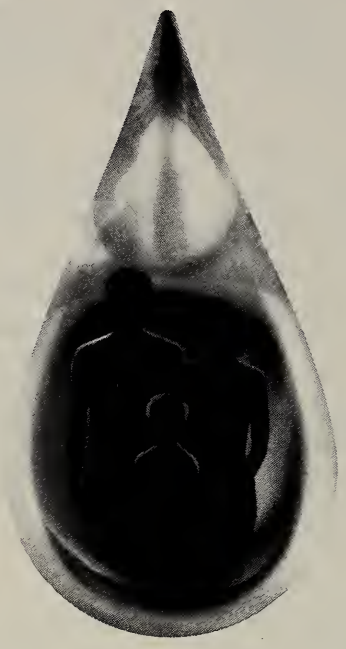
Pneumocystic Carinii	102
Kaposi's Sarcoma	11
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	111

Source: Arkansas Department of Health.

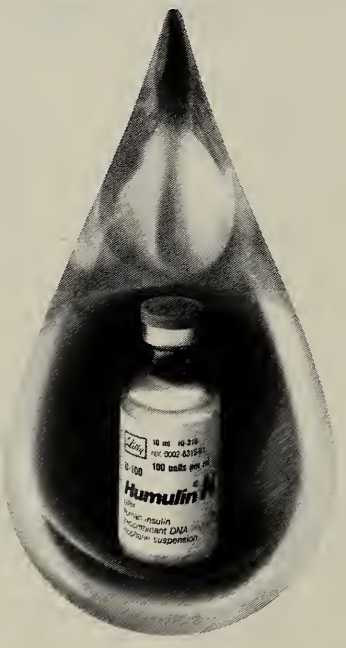
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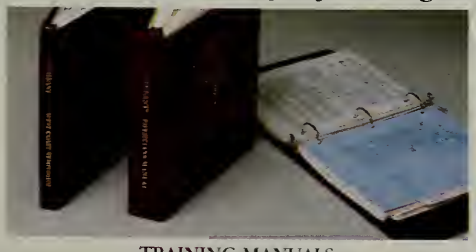
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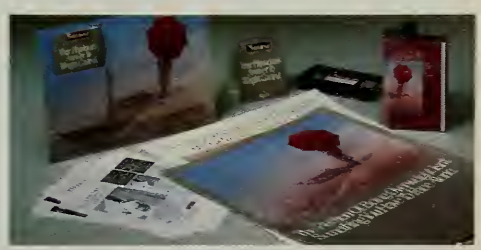
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EDITORIAL

Delinquent Youths: Our Responsibility as Physicians



Sam L. Shultz, M.D., Pediatrics

A sizable number of children and adolescents, many with complex health care problems, can be found in our nation and our state at any given time. Historically, they have received little attention from health professionals, yet their needs are great. I am referring to the youngsters in detention facilities.

National statistics from the Justice Department tell us that approximately 500,000 children and adolescents are incarcerated per year with the average daily census in all facilities topping 53,000. In Arkansas, approximately 625 are committed annually to the state's two detention centers. I had the opportunity to observe and study the characteristics of this population during the two years as medical director of the state's Juvenile Justice Centers (JJC's).

It is apparent that this is not a healthy population of kids. The largest published studies cite 33-46% of adolescents as having significant medical problems. Dental disease and nutritional deficiencies head the list. Chronic problems such as asthma, vision and hearing problems, and untreated minor trauma go unchecked because of the poverty level so common to these children.

Likewise, young people in detention have taken part in behaviors that result in health problems. The rate of alcohol, tobacco and drug usage is significantly higher than in non-delinquent groups. The incidence of significant injuries is likewise much higher due in part to the delinquent's poor judgment and feelings of omnipotence.

While STD's pose a major problem, it would be a mistake to assume that the majority of delinquent youths are affected. A national average of 15-20% of admissions have STD's; our 1988 figures were 11% for girls and 4% for boys.

Once adolescents are in detention, health problems continue. Respiratory infections and injuries accounted for the majority of sick call visits at the Arkansas JJC's.

Even though health problems are prevalent, a sizable number of juvenile facilities lack regular, comprehensive medical services. According to the National Commission for Correctional Health Care, in 1984 fully 33% of facilities did not have regular sick call. Both mental health and dental services were available in less than half of the facilities. It is important that physicians offer their services to the facilities in their community that house juveniles - county jails, halfway houses, private agencies.

What other role should the physician take in the care of delinquent youth? Since this group infrequently has a primary physician, it would be difficult to identify them in our practices. However, we can:

1. Assist in the provision of community mental health services, especially for the youth returning home after release.
2. Be involved in the followup monitoring of abused/neglected children.
3. Support the provision of counseling services for families whose children are incarcerated.
4. Inform your legislators about the need for improved health care and followup upon discharge.

Involvement with these youngsters, though difficult, can be gratifying. More must be done to support them in their communities since the majority return to the unresolved problems that may have precipitated the behaviors.

If you would like to write a letter to the editorial board of the Journal, direct your comments to Journal of the Arkansas Medical Society, Letters to the Editor, Post Office Box 5776, Little Rock, Arkansas 72215.

Pediatric Outreach Clinics in Arkansas

Charles R. Feild, M.D.*, William T. Dungan, M.D.,Carolyn Marsh, M.S., Paula Patterson, M.A.P., and Robert H. Fiser, Jr., M.D.

One of the needs of rural and small town practice is the ability to refer patients for subspecialty evaluation. As pediatric sub-specialties are traditionally practiced in a tertiary care setting, many children and families journey to Little Rock for care from the staff of the University of Arkansas for Medical Sciences Department of Pediatrics on the campus of the Arkansas Children's Hospital. We describe current efforts to provide support and subspecialty care to areas outside of central Arkansas through a network of outreach clinics. Funding of certain patient services through an innovative state program is also described.

Methods

The Department of Pediatrics' commitment to outreach services beyond the central Arkansas region began with Pediatric Cardiology in 1981. It is of note that Pediatric Cardiology outreach continues to be the most active section of the Department. This division has 60 outreach clinics a year in nine Arkansas communities with an estimated 1,000 outreach patient visits this year.

The subsequent addition of other specialties and sites has been made by the Child Health Management System of the Department of Pediatrics. These are shown in Tables I and II. At this writing, 19 faculty physicians from the Department of Pediatrics participate in outreach clinics. Child Development Clinics also offer psychological evaluation (Helena and El Dorado), and speech/language pathology evaluation (Helena) from the professional staff of the James L. Dennis Developmental Center.

Also, the Department of Pediatrics Northwest Arkansas Neurodevelopmental Clinic was established in Fayetteville in 1985. Headed by a pediatric neurologist, the multidisciplinary staff (Speech/Language Pathologist, Social Worker, Special Education Specialist) has approximately 500 visits annually. In addition the clinic site which is adjacent to the Washington Regional Medical Center also hosts other Department of Pediatrics traveling outreach clinics for the region (with the exception of Pediatric Cardiology).

* Assistant Professor of Pediatrics, Developmental Pediatrics, Dennis Developmental Center, Arkansas Children's Hospital, 800 Marshall Street, Little Rock, Arkansas 72202-3591.

Table I. Outreach Sites

El Dorado	Helena
Fayetteville	Jonesboro
Forrest City	Lake Village
Fort Smith	Mountain Home
Harrison	Texarkana

Services for purposes of evaluation have been made more accessible by a contract between the Department of Pediatrics Child Health Management System and Arkansas Department of Human Services. The Title XX (Social Services Block Grant) Program partially funds outreach evaluation and follow-up of certain diagnoses related to Child Development for children of many families without private insurance or Medicaid, based on family size and income. This Title XX program allows children to be evaluated in their own communities.

Discussion

Subspecialty outpatient activities have been linked to tertiary care inpatient and research facilities. Yet outpatient care does not necessarily require the technological resources of a tertiary center. Certain types of outreach evaluations such as Child Development can involve ancillary health or education professionals from the home community who can be involved in daily or weekly services to the child and family. The needs of the child and family to function in their own community as well as the travel and financial barriers to care have been reviewed.[1]

Table II. Outreach Clinics and Number of Sites

Clinic	Number of sites
Allergy	2
Cardiology	9
Developmental Pediatrics	3
Genetics	3
Hematology	1
Nephrology	2
Neurology	3
Pulmonology	3

Under Public Law 94-142, children with a variety of chronic illnesses may receive special education services under the category "Other Health Impaired".[2] The primary physician's and the sub-specialty pediatrician's roles in preparing an Individual Educational Plan as required by Public Law 94-142 for the patient has been reviewed.[3] In the 1988-89 school year, only 0.06% of Arkansas students were in this category, compared with the national student percentage of 0.17%.[4] By attempting to focus more subspecialty care at the community level, it is hoped that the educational as well as medical needs of public school students may be better identified and met.

The need for expanded services in Arkansas has been acknowledged. Continued expansion of the Department of Pediatrics Child Health Management System across the state was a priority of the Subcommittee on School-Age Children and Youth of the Arkansas Department of Health 1988 Long Range Planning Committee Report.[5] The report noted the large numbers of Arkansas children living in rural areas with few medical providers and the decrease in special transportation programs previously available for patients.

Outreach services may become increasingly important for services mandated by Public Law 99-457 to handicapped and at-risk infants and children 0-5 years old.[6,7] The multidisciplinary evaluation necessary to prepare an Individual Family Service Plan may require the services of professionals not readily available in many areas of the State. Nationally it has been noted that, "Shortages of qualified personnel in the provision of special education and related services to handicapped children are reaching crisis proportions."[7] As Federal funding for Public Law 99-457 is to be spent for coordination rather than direct service, continued availability of Title XX funds to maintain the current level of outreach and hopefully expand is critical.

The Department of Pediatrics has a commitment to make outreach services of sub-specialties available to families and referring physicians in the State. The administrative commitment has been demonstrated by the formation of the Child Health Management System. Clinical support has been evidenced by the investment of time and effort by faculty physicians.

Acknowledgements

The authors thank the many local providers of child health care, the Arkansas Department of Human Services and the staff of the Department of Pediatrics who participated in making this program possible.

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A Fluoride Analysis Program to Reduce Tooth Decay in Rural Children

Wharton A. Nichols, D.D.S.*

In rural Arkansas, children must drink water furnished from a well or spring. They do not have access to fluoridated community water as do urban children. Fluoridated water is an acknowledged successful preventive health measure for the reduction of dental caries (tooth decay) in children and its pain, suffering and considerable costs of repair. To improve the dental health of rural children, the Arkansas Department of Health initiated a program for the analysis of the fluoride level of their drinking water on July 1, 1989. The program's purpose is to provide the analysis information to dentists and physicians who can then properly prescribe the daily amounts of fluoride for the children as a dietary supplement. Daily supplements of fluoride can reduce tooth decay in a manner similar to fluoridated drinking water.

Discussion

Tooth decay remains the most prevalent chronic disease of childhood. Although 78% of Arkansas children between three and seventeen years of age have tooth decay, only an estimated 22% of children receive treatment annually. The incidence of tooth decay can be significantly reduced through preventive measures.

Water fluoridation, the adjustment of the fluoride level in the water of a community water system (CWS)* to an optimal level is the most cost effective and efficient method for preventing tooth decay, and can reduce decayed teeth by 50-65%. Of the 710 CWS's in Arkansas, 210 furnish water with an optimal fluoride level to more than 1.2 million persons, or approximately 50% of the population.[1] The Engineering Division, Arkansas Department of Health, in compliance with the Federal Safe Drinking Water Act, is responsible for determining the fluoride levels of all CWS's and for maintaining a continually updated register listing both optimally fluoridated water systems and nonfluoridated water systems.[2-4]

Children who drink nonfluoridated water can benefit considerably from dietary fluoride supplementation which, if conscientiously and regularly carried out, can reduce tooth decay on an order similar to fluoridated water.[5-7] At present, daily supplements of fluoride are being prescribed by dentists and physicians for many children served by nonfluoridated CWS's. By contacting either the local CWS or the Arkansas Department of Health, the dentist or physician is told the fluoride level in the CWS serving a child for whom a daily fluoride supplement is planned. Then, by applying a regimen approved by the American Academy of Pediatrics' Committee on Nutrition and the American Dental Association's Council on Dental Therapeutics (Table I) which uses two important factors of child age and drinking water fluoride level, a prescription is developed for the individual child.[8,9]

Twenty percent of the Arkansas' population (500,000) received their drinking water from a well or spring. The rural child in this situation has been denied the possibility of being prescribed a dietary fluoride supplement up to now because dentists and physicians were unable to determine the fluoride level in well or spring water. With the new analysis program in operation, every rural child will have the opportunity to receive the same benefits of reduced tooth decay as do urban children.

Authorities agree that the tooth decay reduction benefit of systemic fluoride occurs during the developmental period of enamel of both the primary and permanent teeth which is from two weeks through eight years of age.[10,11] Of greatest benefit is a program of systemic fluoride either through the drinking water or by dietary supplementation that begins at two weeks of age and continues uninterrupted through eight years of age. For this reason, the program of fluoride level analysis is directed toward the newborn child so that fluoride supplementation can be implemented at the most ideal and beneficial age.

The fluoride analysis program operates in the following manner. A dentist or physician who wants a fluoride analysis to determine a prescription for a newborn patient will make a request to the patient's county health department. The request may be brief, must be written on the dentist's or physician's letterhead stationery or on a prescription pad bearing the dentist's or physician's name and address, and should be delivered to the county health department by a parent of the infant patient. On presentation of a valid request, the parent will be given a Fluoride Analysis Kit

* Director, Office of Dental Health, Arkansas Department of Health, 4815 West Markham, Little Rock, Arkansas 72205.

* A community water system is a public water system which serves year-round at least 15 service connections used by 25 residents, and can be the water system of a city, town, rural water association and motor home park.

Table I. Supplemental Fluoride Dosage Schedule (milligrams/day)				
	Concentration of fluoride in drinking water (parts per million or ppm)			
Age	< 0.3 ppm	0.3-0.7 ppm	> 0.7 ppm	Type of Preparation
2 wk-2 yr.	0.25 mg/day	0	0	Drops
2-3 yr.	0.50 mg/day	0.25 mg/day	0	Drops/Tablets
3-16 yr.	1.00 mg/day	0.50 mg/day	0	Tablets

at no cost. The kit supplies instructions for its use, a special bottle for a sample of the child's drinking water, a registration card, a pre-paid mailing label and a mailing box. A parent can take the sample of the home's well or spring water, fill out information on the registration card and mail both the bottled water sample and card in the box using the pre-paid label to the Arkansas Department of Health in Little Rock. The analysis will be conducted in the Health Department's Water Laboratory and the result will be sent to the dentist or physician as recorded on the registration card. A copy of the analysis result will be maintained at the Health Department for future reference. The cost of the analysis service is funded by the Arkansas Fluoridation Program.

Fluoride drops and tables are commercially available from pharmacists throughout Arkansas in dosages compatible with the recommended schedules in Table I. The Medicaid program will pay for the dietary supplemental fluoride prescriptions for children participating in the Medicaid program. As a precautionary measure, the Committee on Nutrition and the Council on Dental Therapeutics recommend no more than 120mg of fluoride be dispensed and available to a young child at one time.

Dentists and physicians are now aware that even for those children considered to be drinking water from optimally fluoridated CWS's, there are large numbers not receiving enough of the fluoride to obtain the benefits of reduced dental decay. Infants who are totally breast-fed or who drink a pre-mixed formula using bottled water, are not receiving the proper amount of fluoride for it to be beneficial. Many physicians feel that infants and children up to three years of age drink little or no water as such, and that what water they do receive comes mainly from milk. All commercial premixed formulas and bottled waters are non-fluoridated. Both human and cow's milk is deficient in active fluoride ions due to binding with calcium ions. Following careful evaluation of feeding practices and determination of need, fluoride supplementation of the diets of these groups of children is recommended by the American Academy of Pediatrics.[12,13]

Summary

Daily ingestion of optimal amounts of fluoride has been shown to significantly reduce the incidence of tooth decay in children. Fluoridated drinking water is the most effective and efficient primary source of fluoride. Children who do not drink sufficient fluoridated water should receive supplemental fluoride in the form of drops and tablets. Fluoride supplements beginning with the newborn infant at two weeks of age should be prescribed in accordance with the dosage schedules of the American Academy of Pediatrics and the American Dental Association. Fluoride levels of the drinking water source must be determined before prescribing a fluoride supplement. The Arkansas Department of Health offers dentists and physicians a program to analyze the fluoride content of private well or spring water. The program operates through local County Health Departments. Information about the fluoride level in the drinking water of a CWS is available by contacting either that particular CWS or the Engineer Division, Arkansas Department of Health. Questions about fluoride supplementation and/or optimally fluoridated CWS's should be directed to Dr. Wharton A. Nichols, Office of Dental Health, Arkansas Department of Health, 4815 West Markham, Little Rock, AR 72205, (501) 661-2483.

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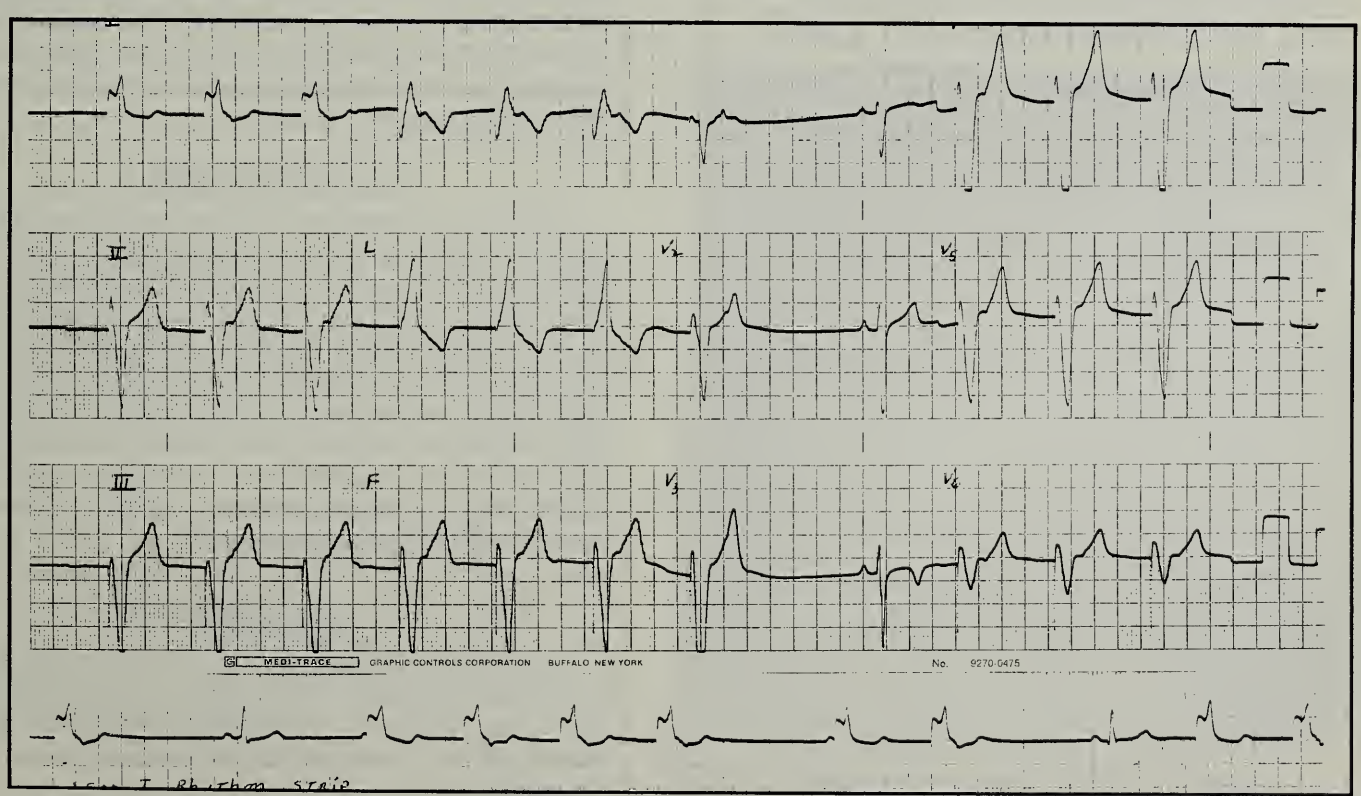
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DISCUSSION:

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The editor wishes to thank Dr. Furlow who practices cardiology in Conway, Arkansas for his contribution to this month's feature.



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Radiologic Evaluation of Traumatic Injury of the Thoracic Aorta

Timothy C.McCowan, M.D.,*, David W. Weiss, M.D., Ernest J. Ferris, M.D., and L. Scott Cook, M.D., Ph.D.

Aortic injury is a frequently lethal complication of blunt chest trauma. Thoracic aortic injury is most often due to automobile accidents, but falls from significant heights and airplane crashes are also rare causes.[1-3] The incidence of concomitant injuries is high, and only 10-20% of patients survive the initial event to reach the hospital.[4] Of those patients with aortic rupture who reach the hospital, 50% will die within the first 24 hours.[5] Another 1-2% may go unrecognized and remain undiagnosed for up to 40 years. Physical signs and symptoms are non-specific and include changes or discrepancies in the peripheral pulses, bruits, dyspnea, and hypertension in the upper extremities.[6] Proper and timely radiologic imaging is of prime importance in the diagnosis of this entity.

Case Report

A 25-year-old male was involved in a high speed automobile accident. He was hypotensive at the scene of the accident, but his blood pressure improved with intravenous fluids. He was transferred to the University Hospital in Little Rock and arrived at the emergency room 7 hours after the accident. A supine anterioposterior chest radiograph with a nasogastric tube in place revealed widening of the superior mediastinum, deviation of the nasogastric tube and trachea to the right, lack of definition of the aortic knob, right pulmonary contusion, and elevation of the left hemidiaphragm (Figure 1). No rib fractures were identified. The possibility of aortic and diaphragmatic rupture was questioned, and the patient was immediately taken to the angiography suite. Via a right femoral artery approach, a 7 F pigtail catheter was carefully advanced into the ascending aorta without difficulty. Contrast injection and filming in the right posterior oblique projection showed an obvious disruption of the aortic arch just distal to the left subclavian artery (Figure 2). The catheter was carefully removed from the ascending aorta, and the patient was immediately taken to surgery where an aortic rupture corresponding to the arteriogram was found and repaired with a tube graft. The patient also had repair of a left hemidiaphragm laceration.

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Discussion

The chest radiograph is frequently the first imaging study to suggest the diagnosis of aortic rupture and should be obtained in all patients sustaining significant chest trauma. A variety of findings on the chest radiograph may indicate the possibility of aortic injury. These include: a mediastinal width of more than 8 cm or a mediastinal to chest width ratio at the level of the aortic arch of greater than 0.25; indistinctness of the aortic arch or aortic contour; displacement of the trachea, nasogastric tube, or left mainstem bronchus; apical pleural cap; and rib fractures, especially of the first or second ribs.[7-9] Unfortunately, all of these signs are associated with high false-positive and false-negative rates. Enlargement of the mediastinum (>8 cm) will be present in 75.5% of the cases of aortic rupture, but will also be present in up to 73.7% of patients with severe blunt thoracic trauma without aortic injury. Indistinctness of the aortic contour likewise is present in 75% of patients with aortic tears, but may be seen in 95% of trauma patients having a normal aortogram.[8] Tracheal and

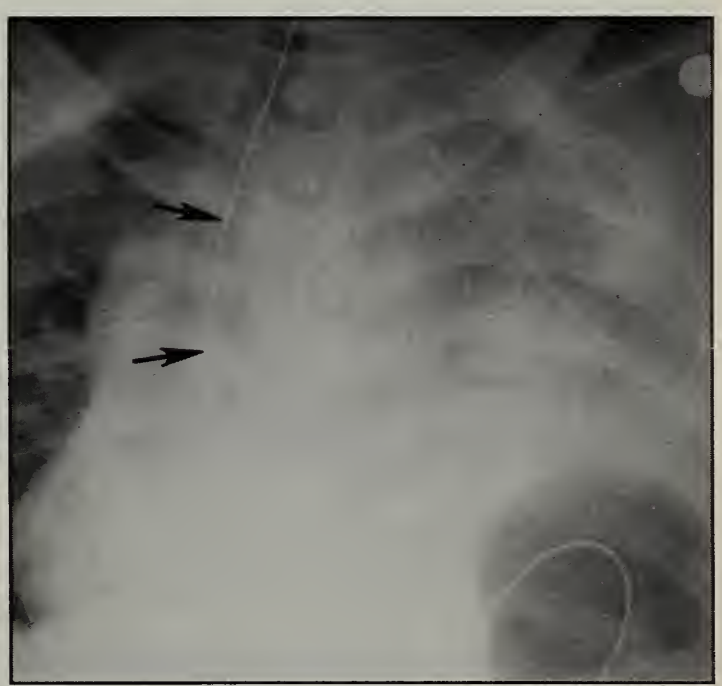


Figure 1. Supine anterioposterior chest radiographic shows a widened mediastinum, deviation of the trachea and nasogastric tube to the right (arrows), and elevation of the left hemidiaphragm.

esophageal displacement are somewhat more specific for aortic injury, but are seen in only approximately 65% of aortic ruptures. Apical pleural caps and upper rib fractures are notoriously poor predictors of thoracic aortic injury due to blunt trauma.[9]

Arteriography is the method of choice for the evaluation of acute thoracic aortic injury. A transfemoral approach is the quickest and safest route unless femoral pulses are diminished. In that case, an axillary artery puncture is indicated. Proper angiographic technique and excellent image quality is essential. This includes: large diameter (7 F) pigtail catheter well-positioned in the ascending aorta, high volumes (60 ml) and rates (30 ml/sec) of contrast injection, high density (76%) contrast, a rapid filming rate (2-3 films/sec), and gentle manipulation of catheters and guidewires. A 45° left anterior oblique or biplane anterioposterior and lateral projections of the aortic arch should be the first study performed. Cut-films should be obtained. At least one other projection is required if no abnormalities are seen on the initial study. Subtraction images are frequently helpful in detecting subtle injuries and should be routinely obtained if the non-subtracted images appear normal. Careful attention should be paid to the great vessels arising from the aortic arch. If the aortic arch and ascending aorta are normal, the descending aorta to the level of the diaphragm should be evaluated by biplane cutfilm imaging after retracting the catheter to the proximal descending aorta. Specific angiographic findings indicating aortic injury are: presence of a false aneurysm, intimal tear, post-traumatic dissection, and post-traumatic coarctation.[10,11] In over 80% of patients the injury occurs at the aortic isthmus just distal to the insertion of the ligamentum arteriosum. Although 96% of patients have a single aortic injury, the incidence of multiple injuries is significantly increased if the brachiocephalic artery (the second most common site of injury) is involved.[8]

Computer tomography and magnetic resonance imaging have little role in the diagnosis of acute trauma to the thoracic aorta. They can be extremely helpful, however, in the evaluation of patients who present with delayed recognition of aortic injury. Immediate surgical repair is indicated in acute injuries.

Conclusion

Blunt thoracic trauma leading to aortic injury is often rapidly fatal. Patients who survive to reach the hospital need prompt and definitive diagnosis. Arteriography is the imaging method of choice. The need for angiography should be dictated by the clinical findings and the severity of the trauma and not based on the findings of the chest radiography although certain chest radiographic signs can be helpful in suggesting the diagnosis of thoracic aortic injury.

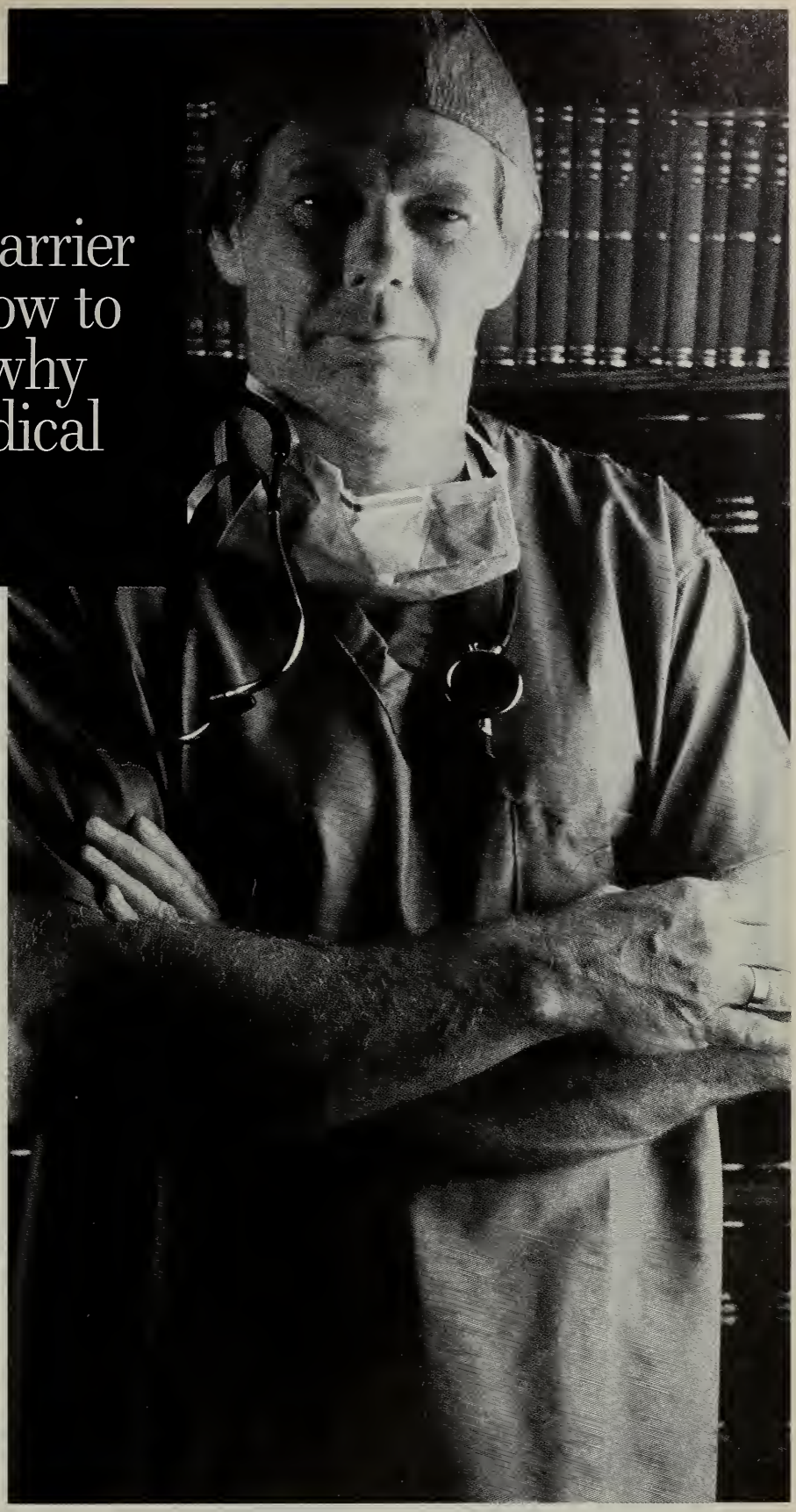


Figure 2. Arteriogram in the left anterior oblique position demonstrates irregularity of the contrast column at the aortic isthmus (arrow) due to aortic disruption.

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The Role of the Occupational Health Nurse

Mona Ray Fields, Ed.D., R.N., Paul Rountree, M.D.*, and Mary Ann Coleman, B.S.

Occupational health nursing is recognized within the nursing profession as a subspecialty of community health nursing. A baccalaureate degree or master's degree in nursing are the preferred educational preparations for occupational health nurses. Previous work experience in emergency nursing, community health nursing, outpatient settings and/or adult health ambulatory care settings is recommended.[1]

Multifacted Profession

The role of an occupational health nurse is multifaceted, incorporating traditional nursing skills with an expanded function of management of minor illness and of health promotion for the individual worker and safety promotion within the work environment. At times these functions are shared with other team members such as a physician or a safety engineer. In other settings the nurse may be almost totally responsible for the health and safety program of a company. In general, whether alone or as a part of a team, the occupational health nurse has four primary objectives: to provide emergency care as needed; protect the employee from safety and health hazards in the work place; promote a safe and healthful workplace and; promote healthy lifestyles for workers and their families and assist them in meeting their health and welfare needs.

In order to meet the above objectives the occupational health nurse functions in the area of administration, direct nursing care, environmental surveillance, health education, counseling and research. These functions require the nurse to engage in activities ranging from primary prevention and health promotion to treatment and rehabilitation. The American Association of Occupational Health Nurses recommended a ratio of one nurse per 300 workers, 2 per 600, 3 per 1000 and then one additional nurse for each additional 1,000 workers until a level of 5,000 workers is reached. At that time it is recommended that an additional nurse be added for every 2,000 employees.[2] These numbers are considered necessary if a nurse is to successfully fulfill all the functions of an occupational health nurse.

Administrative functions consume a large part of the occupational health nurse's time. It is important for the employing agency to remember that just as other departments need adequate clerical assistance so does the occupational health and safety program. The administrative functions center around the operation of an occupational health service involving such activities as maintenance of employee records, development and maintenance of policy and procedure manual, training of auxiliary health personnel and coordination of emergency procedures. Additional activities include cooperation with federal and state occupational regulatory bodies and participation in student educational placement programs. Another activity is periodic evaluation of the occupational health service. This list is not intended to be all inclusive but gives some notion of the activities under function of administration.

"The occupational health nurse has four primary objectives: to provide emergency care as needed; protect the employee from safety and health hazards in the work place; promote a safe and healthful workplace and; promote healthy lifestyles for workers and their families."

To assist the nurse in the administration of an occupation health services the American Association of Occupational Health Nurses has published some excellent materials. The nurse new to occupational health would find the following references helpful: 1) Principles of Management-Nurse Relationships in Occupational Health Nursing;[3] 2) A Guide for Establishing an Occupational Health Nursing Service[4]; 3) A Guide for evaluation of an Occupational Health Nursing Service[5], and 4) A Guide for the Preparation of a Manual of Policies and Procedures for the Occupation Health Service.[6]

A second function of the occupational health nurse is environmental surveillance. The nurse must monitor the work environment for health hazards and attempt to establish cause and effect relationships between health and illness or injury. The nurse probably has more opportunity to do this than any other member of the occupational health team

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because of daily contact with workers and knowledge about the health problems of the workers and knowledge of potential occupational hazards.

Obviously the nurse alone is not responsible for surveillance activities. They involve members of management, occupational safety personnel, industrial hygienists and physicians. Activities may also involve OSHA personnel.

The third function for an occupational health nurse is direct nursing care. The direct care can range from assessment (pre-employment physicals) to rehabilitation. To be more specific the nurse may be involved in assessment, screening, treatment of acute and chronic illness, immunization programs, treatment of injury and rehabilitation. In order to maximize the effects of the direct care activities the nurse will perform many health education activities and will utilize community resources as appropriate to the situation.

Health Education

The functions of health education and counseling are so interwoven in occupational health nursing that it is often difficult to separate the two. Within an occupational health service, health education and counseling generally focus on stress reduction, hypertension, alcoholism, drug abuse, smoking cessation, weight reduction and nutrition, fitness and awareness of safety and health hazards. When the industry has provided a very comprehensive program, topics such as lifestyle and health, prevention of "heart diseases," personal hygiene, treatment of minor illness at home (colds and flu), dental health, family planning, and sexually transmitted diseases may be included.

In setting up these programs the nurse must assess the interest, knowledge and attitudes/beliefs of the target group as well as their customary method of gaining health information. In addition the corporate attitude and the cost effectiveness of the activity must be ascertained.

Health education activities must include in-service programs on health and safety. The Occupational Health and Safety Act of 1970 requires that workers be informed of any hazards they will encounter in the workplace. These classes usually are conducted by the occupational health nurse with assistance from other team members as needed.

An important part of the health education program involves interpreting the health and welfare benefits to employees. This is enhanced by sharing the community resources available to the employee and other family members. Clinical experience has demonstrated that when an occupational health nurse assists an employee in meeting family needs, there is less job-related injury and illness.[7]

Still another part of the health education function of the occupational health nurse is assisting the worker to view work as a developmental task. This use of anticipatory guidance enables the worker to better meet some of the possible crises and challenges that may arise. Many corporations expect the occupational health services to assist employees as they move toward retirement.

This paper is intended to acquaint the reader with an overview of the type activities the occupational health nurse might provide.

Research

The final function involves research. This activity consumes the least amount of time for the occupational health nurse. Most nurses are not involved in research. Part of the reason for this is the lack of preparation on the part of the nurse. In a survey by Coleman, Rountree and Fields, 24% of the occupational health services in Arkansas were headed by a licensed practical nurse who has had no preparation in research.[8] Based on personal knowledge of the authors many of the registered nurses are not baccalaureate or masters prepared and again have not been introduced to the research process in their education programs. Thus the practice of hiring unprepared personnel by the industry prevents full enactment of the role and hinders the development of high quality occupational health services.

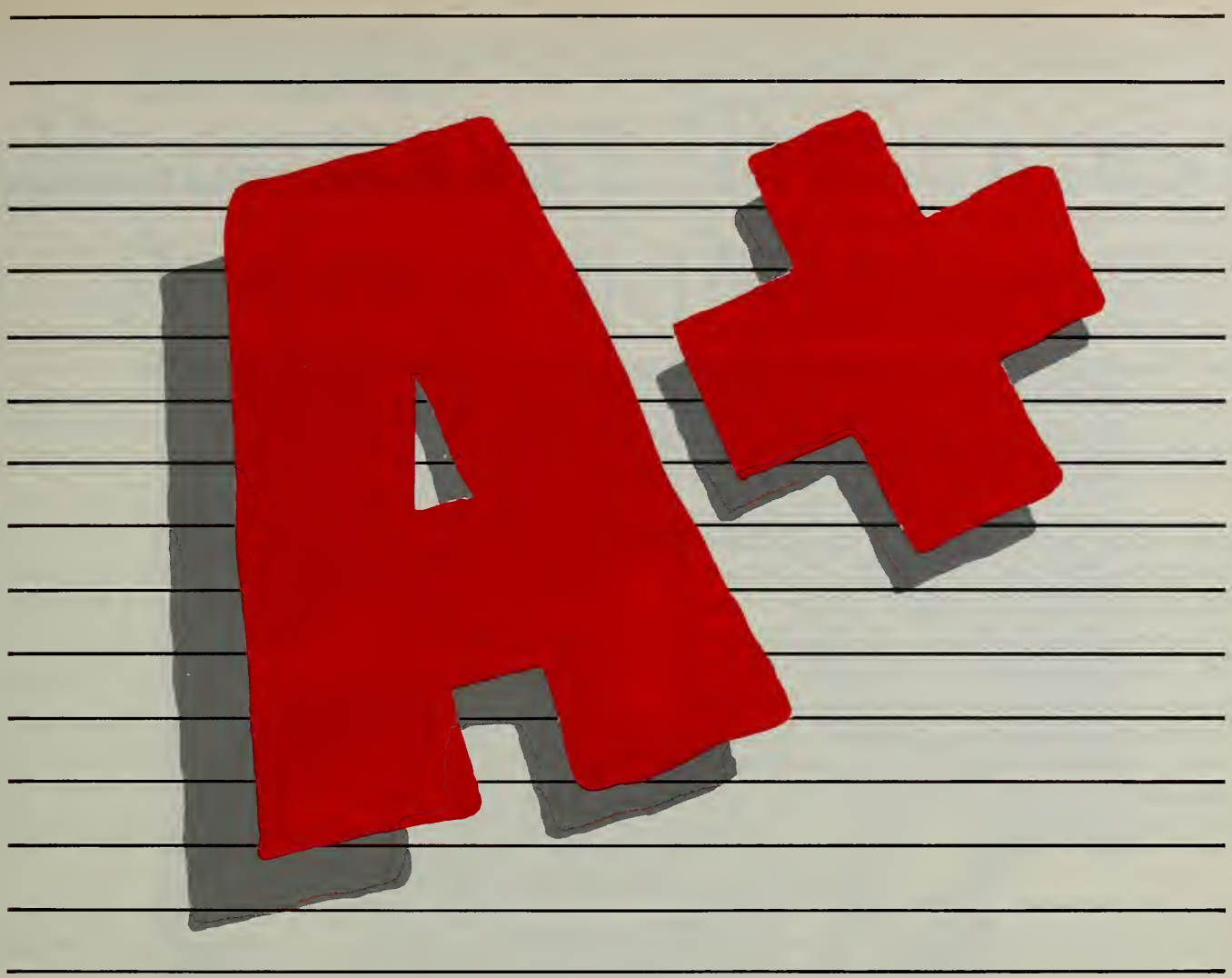
Conclusion

The foregoing functions of an occupational health nurse are consistent with the reality of practice. Gleniecki reported a survey of occupational health nurses in California performed all of the functions listed except research.[9] However, she reported one administrative activity not delineated under the administrative function, budgeting. Therefore, it appears safe to conclude that the theoretical description of the role of an occupational health nurse is closely matched by the functions performed in the work setting.

As one can gleam from the activities described, the role of an occupational health nurse involves many functions. The nurse who fills this role must be well prepared educationally and versatile. Only with these attributes can the objectives of an occupational health nursing service be met.

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February 2-3

Advances in Oncology - 1990. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson, University of Kentucky, College of Medicine Office Building, Lexington, KY 40536-0086; (606) 233-5161.

February 3-10

1990 Winter Seminar. Presented and sponsored by Baptist Medical Center, Medical Affairs Department. Snowmass, CO. Twenty Category I credit hours. Fee: $325, physicians; and $200, nurses, residents and allied health professionals. For further information contact the Medical Affairs Department, Baptist Medical Center, 9601 Interstate 630, Exit 7, Little Rock, Arkansas 72205-7299.

February 16-18

Pediatrics in Progress. Presented by Richard MacKenzie, M.D. (Adolescence); Richard Evans III, M.D. (Allergy); James E. Rasmussen, M.D, (Dermatology); Felix A. Conte, M.D. (Endocrinology); Samuel L. Katz, M.D., (Infectious Disease); and Mel Senac, M.D. (Radiology). Sponsored by the American Academy of Pediatrics. Hyatt Regency Embarcadero, San Francisco, CA. Sixteen Category I credit hours. Fees: AAP Resident Fellow, Candidate Fellow and Allied Health Professionals, $220; AAP Fellow, $300; Nonmember Physician, $365. Further information call 1 (800) 433-9016.

February 22-24

The New Orleans AIDS Conference: Management of HIV Disease for the Primary Care Physician. Presented by Robert Redfield, M.D., Walter Reed Hospital; Michael Hickey, M.D., San Francisco; Michael Polis, M.D., National Institutes of Health; and Ronald Grossman, M.D., New York. Sponsored by the Louisiana State University Medical School and the AIDS Education and Training Center. New Orleans Hyatt Regency Hotel, New Orleans, LA. Fee: $210 before January 25 and $225 after January 25. For further information contact Mr. Bart Reilly, AIDS Education and Training Center, 1541 Tulane Avenue, New Orleans, LA 70112; (504) 568-3855.

February 25 - March 1

Twenty-first Family Medicine Review - Session I. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson, University of Kentucky, College of Medicine Office Building, Lexington, KY 40536-0086; (606) 233-5161.

March 30-31

Contemporary Pediatrics for the Practicing Physicians. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson, University of Kentucky, College of Medicine Office Building, Lexington, KY 40536-0086; (606) 233-5161.

March 30 - April 1

Pediatrics 1990. Presented by Elizabeth R. McAnarney, M.D. (Adolescence); Raymond V. Caputo, M.D., (Dermatology); Sarah S. Long, M.D. (Infectious Diseases); Avroy A. Fanaroff, M.D. (Neonatology); Michael J. Goldberg, M.D. (Sports Medicine). Sponsored by the American Academy of Pediatrics. Marco Island Hilton Hotel, Marco Island, FL. 16 Category I credit hours. Fees: AAP Resident Fellow, Candidate Fellow and Allied Health Professionals, $220; AAP Fellow, $300; Nonmember Physician, $365. Further information call 1 (800) 433-9016.

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Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

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Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, fourth Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Rom G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08

Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
*Urology Morbidity and Mortality Conferenc*e, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room

Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center

Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

Medicine in the News

Drug Therapy Compendium Available

Excerpta Medica, an Elsevier Company, announced that the *Compendium of Drug Therapy* would resume annual publication with the Spring 1990 edition.

The book will be published in two editions: FP/GP/DO and IM/CARD/GASTRO. These were the original classic edition of this popular drug reference which was first published in 1980.

Drug information in the *Compendium* is easily accessible. Brand names and generic names are listed together alphabetically. All drug information charts are written in one consistent format. All contraindictions, warnings, and precautions are included. The drug identification section contains physical descriptions of over 1800 prescription and OTC drugs, including dosage strength, color, shape, scoring and manufacturers' identification code. For quick identification, products are arranged by color. Product identification codes are listed numerically for each major manufacturer, with corresponding product names and dosage strengths.

A new editorial feature of the Spring 1990 edition of the *Compendium* is that the tabs will be identified by physiologic systems and therapeutic categories. In addition, a therapeutic index will be added which lists therapeutic categories and conditions. This new index will direct physicians to the page or chapter where they will find drug information to treat the condition.

American College of Alogologists

The American College of Alogologists (ACA) is an organization of physicians who are primarily interested in the field of chronic pain medicine. As a group they are resolved to promote the development of a scientifically based bio-psycho-social approach to the patient in chronic pain. They are interested and involved in the basic science and clinical research dealing with chronic pain and in the application of these data to the development of diagnostic and treatment methods in the clinical practice of chronic pain medicine.

The membership is concerned with the lack of scientific discipline and adequate clinical training that typifies the majority of practitioners who are attempting to treat chronic pain patients at this time. The membership is made up of physicians with substantial dual training in psycho-social medicine as well as in a major field of biomedicine (i.e., psychiatry plus a major branch of somatic medicine such as internal medicine, neurology, orthopedic surgery, neurosurgery, general surgery, physical medicine, etc.)

If any physicians are interested in joining ACA, they can contact Gay R. Anderson, M.D., Executive Secretary, American College of Alogologists, 5410 Highway G, Winneconne, WI 54986.

Arkansas Taxpayers Due over $140,000

The Internal Revenue Service is looking for Arkansas residents whose refund checks worth more than $140,000 were returned as undeliverable by the Postal Service.

Over 400 refunds remain unclaimed by Arkansas residents and businesses, according to Public Affairs Officer, Ken Hubenak. The average refund is about $350 and the largest refund is almost $7,000. Most of the

refunds are for 1988 tax returns but the earliest one is for a 1980 tax return. When refunds are returned by the Postal Service, the IRS attempts to find the taxpayers and deliver the checks but there are some who cannot be found.

In order to assure that refunds will not become undeliverable you have the option of filing returns electronically beginning with your 1989 federal tax return to be filed by April 16, 1990. Qualified return preparers and those transmitting returns can send computer prepared tax returns over the telephone line to IRS in Cincinnati. There is also the option of having refunds directly deposited to accounts at financial institutions.

Taxpayers who are expecting a refund and have moved or changed their name are encouraged to contact the IRS. The toll-free number to call is 1 (800) 424-1040.

When inquiring about a delayed refund, the IRS suggests that taxpayers furnish the names and addresses shown on the return, social security numbers and the type of forms filed. The corrected names and addresses should also be given if different from those shown on returns. Generally undelivered refund checks can be issued within 4 to 6 weeks.

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AMS NewsMakers

Two AMS physicians recently attended the Medical Education Retreat sponsored by the Baxter County Regional Hospital in Mountain Home. Drs. **David L. Stewart** of Benton, and **J. Warren Jacks** of Bentonville, attended the retreat which included topics of care for patients who require some type of surgical intervention. Both physicians are family practitioners.

F. Hampton Roy, M.D., a Little Rock ophthalmologist, was one of the instructors at the Allergan Medical Optics Singlestitch Systems Seminar on phacoemulsification and small incision lens implantation held in New Orleans last month. The course is designed to teach other ophthalmologists how to perform singlestitch eye surgery.

The new ICU-CCU and surgery waiting area at North Arkansas Medical Center was dedicated to the memory of the late **Joe Bill Wilson, M.D.**, of Harrison. A plaque will also hang in the waiting area.

Joycelyn Elders, M.D., the director of the Arkansas Department of Health, was appointed by Governor Bill Clinton to the 16-member Wastewater Treatment Task Force. The task force will assess wastewater needs of small communities and develop inexpensive and efficient solutions for meeting water quality regulations.

The new vice president of the Southern Medical Association is **John F. Redman, M.D.**, a Little Rock urologist. The SMA elected Dr. Redman at its 83rd Annual Scientific Asssembly in Washington, D.C.

Hugh Edwards, M.D., a family practitioner from Searcy, retired last month. Dr. Edwards practiced in Searcy for 43 years and is a Life Member of the AMS.

The newest member of the Board of Advisors of St. Edward Mercy Medical Center is **Hugh Lewing, M.D.** Dr. Lewing, an internist, has served as chief of staff of St. Edward.

Dr. Ralph Maxwell, a general practitioner in Monticello, was honored at the UAM homecoming as one of two outstanding alumni of the university. He is the chairman of the board of Drew Memorial Hospital.

The featured speaker at the North Little Rock Boys Club educational seminar "Sports Medicine" was **Reed W. Kilgore, M.D.**, a North Little Rock orthopaedic surgeon. Dr. Kilgore provided information to coaches about the medical treatment they can provide for their athletes.

John Guenthner, M.D., a 30-year member of the Arkansas State Medical Board, was presented a certificate in recognition for his years of service to the State of Arkansas. **Dr. Joe Verser**, secretary of the Arkansas State Medical Board presented the plaque which Governor Bill Clinton had signed. Dr. Guenthner is a life member of the Arkansas Medical Society.

Four AMS physicians were appointed by Governor Bill Clinton to the Rural Development Study Commission. Drs. **Hoy B. Speer, Jr.**, Stuttgart, **Donald A. Toatley**, Pine Bluff, **John D. Mesko**, Mena and **Cynthia N. Frazier**, Little Rock, were named to the commission to study the possibility of forming a rural development institute for the state and to investigate how other states maintain their rural populations. Drs. Toatley, Mesko, and Frazier practice obstetrics and gynecology and Speer is a family practitioner.

The eighth annual Cancer Symposium in El Dorado featured several El Dorado and AMS members. Drs. **Moises Menendez, C. E. Tommey, Donna Zahniser,** and **William Scurlock** all gave presentations. All the physicians, with the exception of Zahniser, an oncologist, are general surgeons.

J. D. Rankin, M.D., of Hamburg, completed the Advanced Trauma Life Support Course. Dr. Rankin is a family practitioner.

Mark Your Calendar Now!
May 3-5, 1990
114th Annual Session of the Arkansas Medical Society
Arlington Hotel, Hot Springs

New Members

Phillips County

Greening, Billy E., General Practice and Pediatrics. Born October 14, 1947, Nacogdoches, TX. Pre-medical education, Lamar University, Beaumont, TX and University of the State of New York, Albany, 1983. Medical education, American University of the Caribbean, 1987. Internship, Emory University, Atlanta, GA. Residency, Blank Children's Hospital, Des Moines, IA.

Pulaski County

Bates, Stephen R., Pediatric Neurology. Born August 17, 1944, London, England. Pre-medical education, King's College, University of London, 1965. Medical education, St. George's Hospital Medical School, University of London, 1968. Internship/residencies, St. George's Hospital, London, England; Children's Hospital Medical Center, Cincinnati, OH; and University of Cincinnati Medical Center. Practice experience, St. George's Hospital, 2 years; University of Cincinnati Medical Center, 17 years; Arkansas Children's Hospital, 1 year. Board eligible, Child Neurology and Pediatrics. Member, Hamilton County (OH) Medical Society.

Eidt, John F., Vascular Surgery. Born October 5, 1954, Dallas, TX. Pre-medical education, Notre Dame University, Indiana, B.A., 1973. Medical education, Southwestern Medical School, Dallas, 1981. Internship/residency, Brigham Women's Hospital, Boston, MA. Board certified, Surgery.

Evans, Billy W., Internal Medicine. Born June 2, 1957, Bastrop, LA. Pre-medical education, University of Arkansas, Monticello, B.S., 1979. Medical education, University of Arkansas for Medical Sciences, 1983. Internship/Residency, Duke University Medical Center, Durham, NC. Practice experience, Carl Albert Indian Hospital, Ada, OK, 3 years. Board certified, Internal Medicine.

Jagannath, Sundar, Oncology. Born November 11, 1951, India. Pre-medical education, Maharja Sayajirao University, Baroda, India, 1970. Medical education, Baroda Medical College, 1976. Internship/residency, The Bronx-Lebanon Hospital, Bronx, NY and Ha per-Grace Hospital, St. Antoine, Detroit. Practice experience, M.D. Anderson Hospital, 7 years, UAMS, 1 year. Board certified, Internal Medicine and Oncology.

Smith, Jr., Charles W., Family Practice. Born April 14, 1949, Ft. Lauderdale, FL. Pre-medical education, University of North Carolina, B.S., 1970. Medical education, University of North Carolina, 1974. Internship/residency, University of North Carolina. Practice experience, North Carolina, 4 years; Iowa, 1 year; Ohio, 6 years; and Alabama, 3 years. Board certified, Family Practice. Member, Madison County (AL) Medical Society.

Resident Section

Floyd, Dennis N., Anesthesiology. Medical education, UAMS, 1987.

Frevert, Larry F., Orthopaedics. Medical education, University of Missouri, Columbia, 1985.

Green, R. Clark, Pediatrics. Medical education, UAMS, 1987.

Halinsky, David, Internal Medicine. Medical education, UAMS.

Hudson, Michael R., Pediatrics. Medical education, Texas A & M University, College of Medicine, College Station, 1987.

Johnson, Carl L., Internal Medicine. Medical education UAMS, 1986.

Lawton, Steven K., Urology. Medical education, University of Kansas School of Medicine, Lawrence-Kansas City, 1987.

Lyon, Jack, Family Practice. Medical education, UAMS, 1987.

Norman, Charles R., Ophthalmology. Medical education, UAMS, 1985.

Phillips, Hannah M., Psychiatry.

Rea, Steven D., Emergency Medicine. Medical education, University of Texas Medical Branch, Galveston, 1980. Internship/residency, UAMS.

Medical Student Section

Coleman, Andrew C., Freshman

Rollefsen, Janice L., Freshman

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HOT SPRINGS ARLINGTON HOTEL



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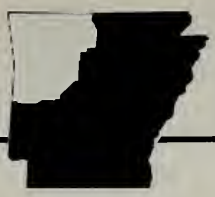


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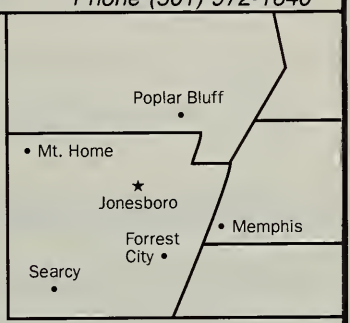
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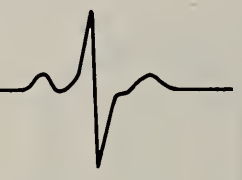
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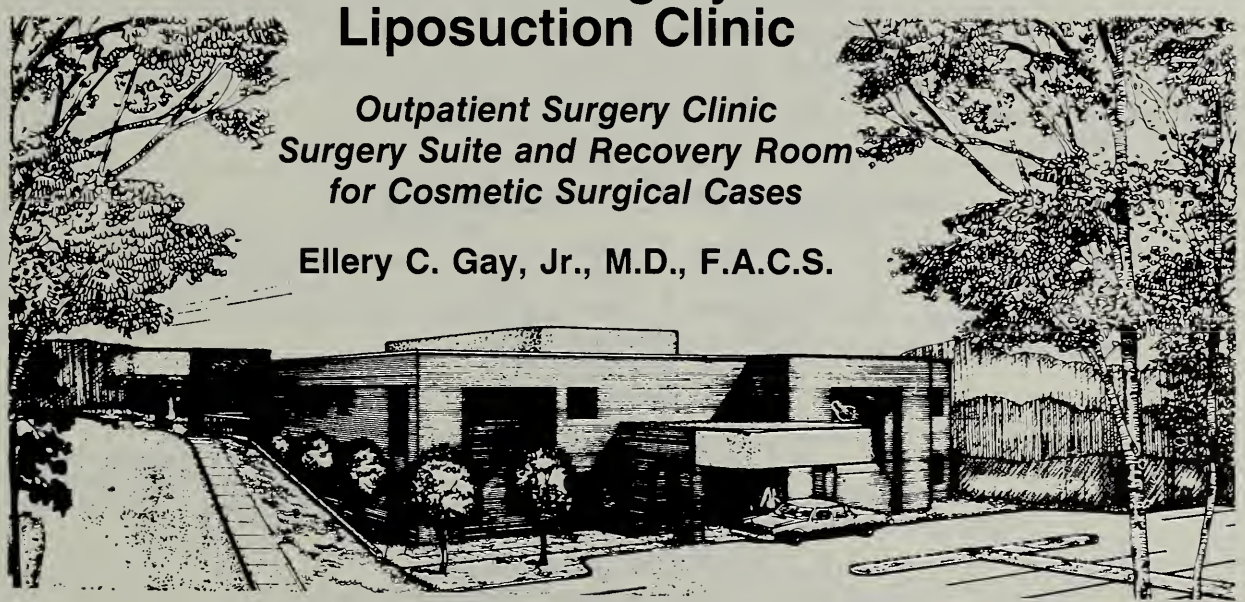
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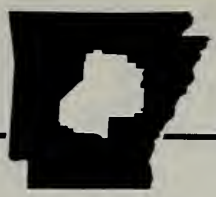
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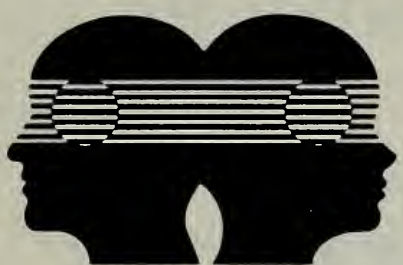
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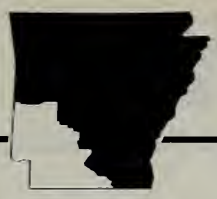
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VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects*.) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

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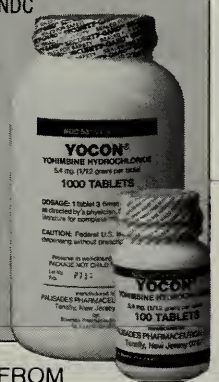
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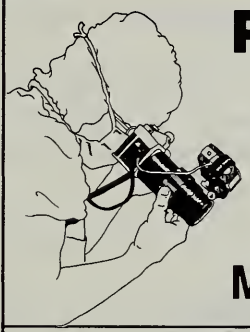
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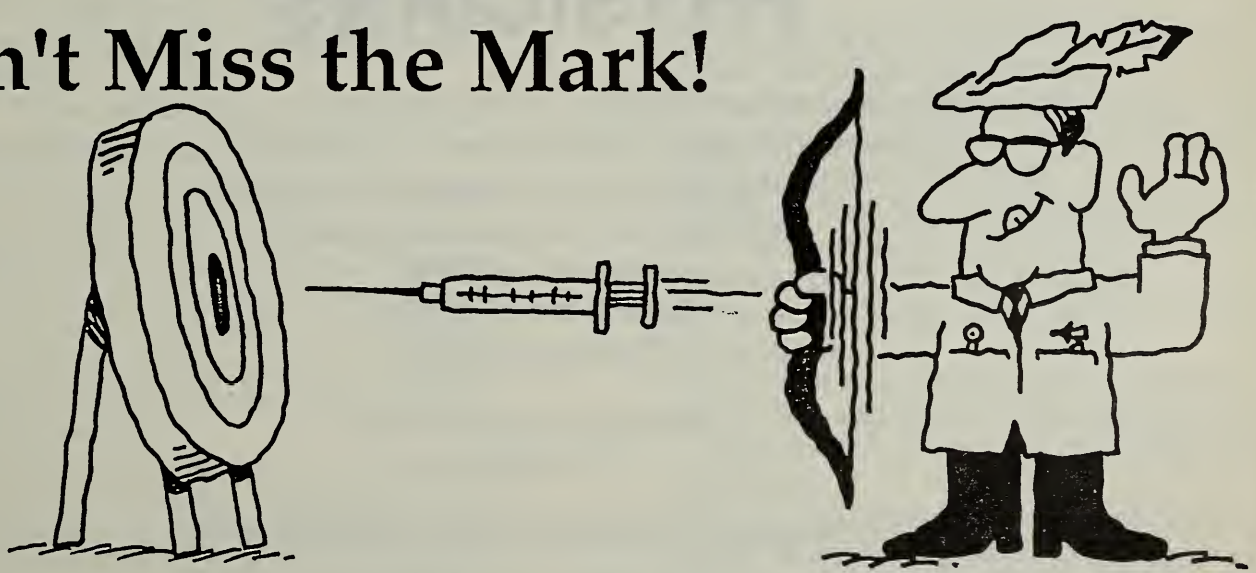
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Update: January 1990 HIV Blood Test Counseling

Robert C. Rinaldi, Ph.D., and John J. Henning, Ph.D.*

Abstract

This manuscript provides physicians with a brief outline of pre-test and post-test counseling to accompany HIV testing.

HIV Blood Test Counseling

The impact of human immunodeficiency virus (HIV) disease on the health care system is increasing. Specialized centers alone are unable to provide all required services. Physicians and other health professionals will encounter a growing number of concerned individuals and family members who need counseling about possible exposure to HIV.

Although counseling related to HIV antibody testing has been widely recommended,[1-3] the medical literature contains little in the way of specific guidelines to conduct this counseling. The following provides a brief outline of some essential elements required to conduct HIV antibody blood test counseling.

Pre-test Procedures

During the pre-test session the physician must provide information about HIV, AIDS, and the test, conduct a sex and drug history, and provide counseling. The patient should be told about the virus, HIV related diseases, routes of transmission, and methods of reducing the risk of infection. This can be accomplished through a variety of mediums including videotape, audiotape, printed matter, group lecture, and one-to-one interaction.[4]

The pre-test session also must include a patient history of sexual behavior and drug use. The physician should use frank, nonjudgemental, open-ended questions to determine the patient's risk of HIV infection. The physician must be sure that the patient understands the words being used.

Discussing sexual behavior is difficult for many patients and physicians. The interview style and terminology used should be tailored to suit the comfort of the individual patient and physician. The patient's sexual orientation is less important than the specific sexual practices in which he or she engages.

Discussing drug use with patients also may be difficult. However, information on intravenous drug use and needle sharing is essential. A full drug use history including substances such as alcohol and marijuana also can be helpful.

Pre-test counseling should include discussion of medical, psychological, and social implications of the HIV antibody blood test. Specific recommendations for behavior change must be based on the physician's assessment of risk. Finally, the physician can assist the patient in deciding whether or not to be tested.

Essential elements of the pre-test counseling session include:

* Ask directly why the patient believes he/she needs to be tested.
* Explain that the test determines the presence or absence of antibodies to the virus.
* Discuss the meaning of a positive test result: The individual is infected and assumed contagious but does not necessarily have AIDS.
* Discuss the meaning of a negative test result: An individual is not currently demonstrating infection but is not "protected" against the virus.
* Discuss the possibilities of false-positive or indeterminate results.
* Discuss ways to modify behavior to reduce risks.
* Discuss the confidentiality of test results in relation to office/clinic procedures and state reporting requirements.
* Discuss potential benefits of anonymous testing.
* Discuss the stress often related to waiting for test results and possible reactions to learning results (eg., depression and anxiety.)
* Discuss potential negative social consequences of being tested and/or being seropositive (employment, housing, insurance, and personal relationship ramifications).
* Assist the patient in making a decision about testing.
* Obtain consent before voluntary testing is con-

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ducted (local statutes pertaining to adults and minors should be consulted).

* Make an appointment for a return face-to-face visit to give and discuss test results.

Post-test Counseling

Disclosure of the test result is best done at the beginning of the post-test session in a direct manner. Many patients anxiously anticipate the test result and are eager to learn the findings. After the result is disclosed, the patient should be encouraged to express feelings. Repeating the patient's remarks and labeling his or her underlying feelings is often helpful.

Reporting a positive result can be difficult. If the patient had predicted a positive result during the pre-test counseling session, the physician might say, "Well your prediction was right. Your tests show that you have the virus." Although it is important to be honest and straightforward in reporting a positive result, it is equally important to give the seropositive patient hope. Quoting the annual percentage of seropositive individuals who actually become ill (approximately 7% of 10% per year) and mentioning the ongoing scientific search for effective treatments and vaccines might prove helpful.

The physician must assess the patient's understanding of the results by asking a question such as "Now that you know you are antibody positive (or negative), what does this test result mean for you?" The physician must help the patient understand and assimilate the information. A review of the information conveyed in the pre-test session should be conducted.

When the result is negative, the patient's understanding of how to prevent future infection must be assessed. When the result is positive, the patient must be advised on how to avoid inflecting others. He or she must understand that infection is probably lifelong but that having a positive antibody test alone does not mean one has AIDS. It is also important to communicate to seropositive individuals that they are probably infectious to others by the established routes of transmission and that there is currently no way to predict with certainty when and if clinical symptoms will develop. Antibody-positive persons should be told:

* Do not donate blood, semen, or body organs.
* Employ what have come to be known as "safer sex practices".
* Do not share personal hygiene items (eg., razors, toothbrushes.)
* Inform physicians and dentists of serologic status.
* Encourage sexual partners and needle contacts to seek evaluation and serologic testing.

The physician must be sensitive to the wide range of psychological reactions possible when the test result is given. For seronegative patients, an immediate reaction of surprise and relief may occur, followed by an overall reduction of psychological distress and anxiety. Seropositive individuals may react with expression of disbelief, anger, fear, guilt, or self-recrimination. Clinical depression often occurs among those testing positive for HIV antibody.[5-6] In some, the depression may lead to suicidal thoughts or attempts.[7]

Seropositive patients sometimes require repeated sessions, supportive services, and monitoring of psychological functioning. A psychiatric referral should be made for patients who require assistance in adapting to current conditions or managing feelings of depression or anxiety beyond what the primary care physician can offer. A patient may also benefit from counseling hotlines, HIV support groups, and/or psychotherapy. A schedule to monitor medical status must be determined as well.

The post-test session also should include an assessment of the patient's commitment to altering high-risk behaviors. The physician must work with the patient to promote behavior change by reiterating routes of transmission, discussing risks, and highlighting methods of risk reduction.

In summary, essential elements of the post-test counseling session include:

* Provide the test result.
* Allow the patient to express feelings and reactions.
* Assess the patient's understanding of the test results.
* Review routes of transmission.
* Assess the patient's psychological condition.
* Recommend psychiatric follow-up when appropriate.
* Assess risk behavior and commitment to risk reduction strategies.
* Recommend medical follow-up.
* Recommend additional support services as needed.

Conclusion

The need for HIV antibody blood test counseling has been widely acknowledged.[1,2] Physicians must be prepared to provide such services for their patients. The brief guidelines presented here serve as an outline for HIV antibody blood test counseling to patients.[8]

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AIDS IN ARKANSAS 1989
January 1 - November 27, 1989

Total number of cases reported	70
Number of deaths	33

CASES BY SEX

Male	61
Female	9

CASES BY RACE

White	49
Black	20
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	43
Homosexual & IV Drug User	5
IV Drug User	8
Hemophiliac	1
Transfusion	2
Heterosexual (Contacts)	8
NIR#	3

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	1
20 - 29	20
30 - 39	36
40 - 49	7
50 - 59	5
60 or more	1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	23
Kaposi's Sarcoma	3
Pneumocystis Carinii and Kaposi's Sarcoma	0
Other Diseases	44

AIDS IN ARKANSAS
1985 - 1989

Total number of cases reported	243
Number of deaths	150

CASES BY SEX

Male	223
Female	20

CASES BY RACE

White	184
Black	57
Other	2

CASES BY RISK GROUP

Homosexual/Bisexual	157
Homosexual & IV Drug User	27
IV Drug User	25
Hemophiliac	2
Transfusion	11
Heterosexual (Contacts)	15
NIR#	6

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	3
20 - 29	78
30 - 39	110
40 - 49	33
50 - 59	11
60 or more	8

OPPORTUNISTIC DISEASE

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Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	120

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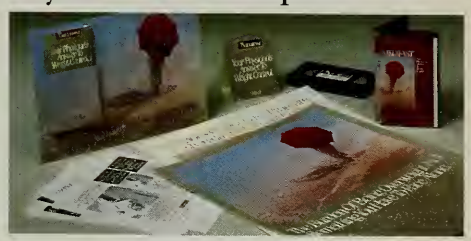
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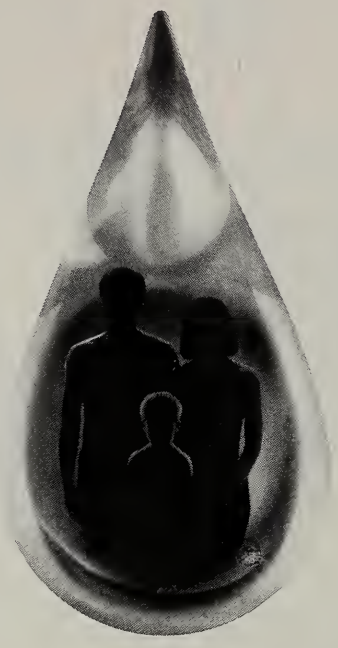
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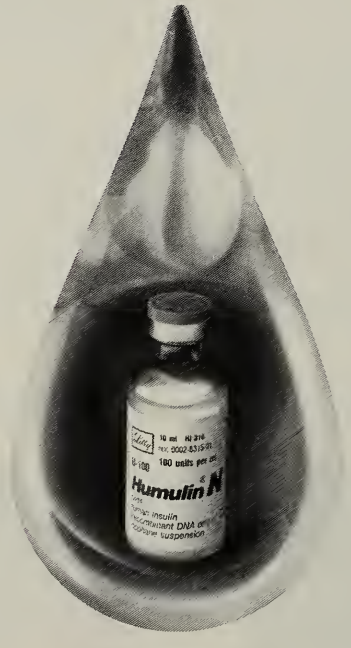
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Recordkeeping: It Could Save Your Practice

Daniel B. Stephens*

Sometimes it is difficult to "communicate" with a combative, confused or unstable patient. In this case, the doctor's records confirmed that the attempt to clarify, answer questions, and be supportive did take place.

Case Presentation

The plaintiff was a 52-year-old female, single, a nurse with a history of both drug and alcohol abuse. She presented at a hospital emergency room suffering from a self-inflicted gunshot wound to the abdominal wall. The bullet did not puncture the peritoneum. She was also suffering from a fracture of the left femur.

Although the plaintiff was confused, psychotic, and hostile during the first several days of her hospitalization, the wound to her side was treated and, when this injury appeared stabilized, on about the sixteenth hospital day, she was taken to surgery where open reduction and internal fixation of the left femur were accomplished, utilizing plate fixation. The plaintiff tolerated the procedure well and was discharged from the hospital the following week to be followed up several times in defendant's office over the next four months.

Almost a year later, plaintiff complained to the defendant doctor that her leg was bothering her and she wanted the plate removed. Although the physician explained to the plaintiff that removal of the plate would probably not put an end to her symptoms, she persisted, and the surgery was performed.

On the day following surgery, plaintiff began to run a low-grade fever and blood count indicated the possibility of a slight infection. The physician prescribed antibiotics and the patient was discharged to be followed-up in the doctor's office.

Two weeks later, the patient presented for an examination of the leg and stated that she was still running a fever. The antibiotics were continued and she indicated that she would continue to use a cane for ambulation.

During her next office visit, the following week, the patient's stitches were removed and a small hematoma was identified in the wound. No fluctuance or any other signs of infection were identified in the wound. A small, subcutaneous area was drained, culture and sensitivity were obtained, and the drained area was packed with idoform gauze. Patient was asked to return in two days.

Later on the same day, the plaintiff went to the hospital emergency room, complaining of pain in her left leg. She was given an injection for pain. On the following day, plaintiff again presented at the emergency room and this time she was admitted to the hospital, a small packing was removed from the wound, and there was slight wound drainage.

During the plaintiff's two-week hospital stay, our insured examined her leg on numerous occasions. The wound was drying up with no signs of deep infection, fluctuance, or excessive redness. New cultures from the leg wound were negative at 48 hours, but at 72 hours showed a few diphteroids and a few staph epidermis. These were designated non-pathogens and skin contaminants. Urinalysis results indicated a urine contaminant of 7000 colonies of psuedomonas.

" What saved the day for this particular physician? Several elements of communication. "

Consult with an internist resulted in his determination that the leg wound was culture negative. Possible considerations included: drug fever, resolving wound infection, or sterile abscess of the buttocks. In order to rule out other possibilities, the internist requested that the antibiotics be

* Mr. Stephens is the general agent for the Medical Protective Company in Little Rock. His address is #10 Corporate Hill Drive, Suite 310, Little Rock, Arkansas 72205.

discontinued, since there were no real indications of infection. Plaintiff continued to run a fever after antibiotics were discontinued.

An x-ray of the thigh revealed no signs of infection. A CAT scan of the thigh was also performed. It was also negative for signs of infection.

Plaintiff's white count at the time of this third hospitalization was 11,500 with 74 segs and 26 lymphs. On discharge, she was sill experiencing essentially the same complaints. No positive findings were identified. Her diagnosis at discharge was cellulitis of the left leg and recalcitrant fever of uncertain etiology.

Our insured physician had seen the plaintiff on almost every day of this hospitalization. She was, he noted, not particularly friendly, but neither was she hostile.

Two years later the plaintiff presented a claim of malpractice, alleging that a sponge has been left in her wound at the time of her surgery and that she was unable to obtain relief from the pain in her leg until she went to the emergency room where they gave her an injection for the pain and removed the offending sponge from the wound.

Plaintiff further claimed that she had a deep wound infection necessitating the third hospitalization. This infection was caused by the presence of a sponge in the wound, she alleged.

Case Discussion

This is clearly a defensible suit. The plaintiff is a woman with a long history of mental problems as well as drug and alcohol abuse. She had not evidenced a great deal of cooperation during the course of her illness. Her mental state may have left her frustrated by the amount of pain she experienced during the healing process, and by the stubborn fever that eluded diagnosis.

It was certainly apparent, almost from the onset of the claim, that no sponge had been left in the wound. But, many physicians have borne the brunt of a negative judgement in similar circumstances. What saved the day for this particular physician? Several elements of communication. First, our insured's notes were thorough and complete. They tallied with the notes of the consulting internist, with the admitting notes written in the emergency room, and with the nurses' notes and test results compiled during the plaintiff's hospital stay. Had any of the key elements of these notes been missing, or unintelligible, a good plaintiff's lawyer might have been able to instill sufficient doubt and sympathy into a jury's reasoning, and a verdict could easily have been made in favor of the plaintiff.

For example, had the emergency room failed to take notes on the removal of the iodoform gauze as well as the small amount of drainage, the plaintiff might have had a much stronger case when it came time to prove exactly what had been removed from her leg and whether or not a massive infection has been present. Also, what if the insured physician had likewise failed to note in his records that he'd packed the wound?

The insured was also saved from the allegations of negligence in failure to treat the so-called deep wound infection. His own examinations, tests, and records negate the presence of such an infection. The records of the hospital emergency room, the tests requested by the consultant internist, and the patient's hospital records all indicated testing for and a decision that deep wound infection was not present.

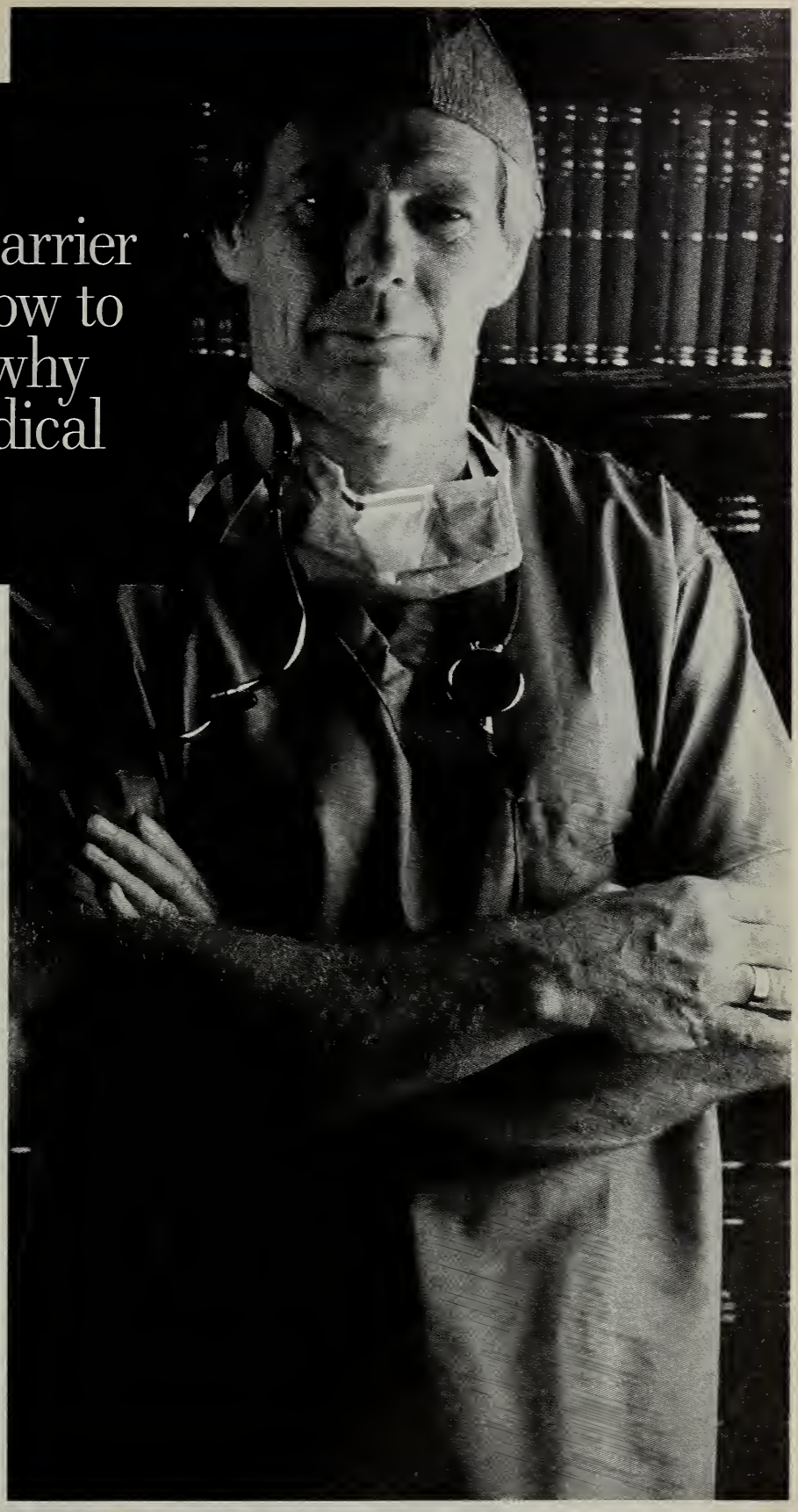
Case Resolution

A plaintiff's attorney was willing to accept these allegations and tried to make a viable case out of them. The plaintiff was not a wealthy women. The attorney had probably accepted the case on a contingency basis.

It became apparent, however, that the medical records spoke for themselves. Numerous test reports, x-ray readings, hospital charts, emergency room entries, and doctor's office records all corroborated the fact that this woman had received proper care.

Without the excellent written communication provided by the health care professionals, this case might well have had a different result. As it is, the defense attorney, understanding the strength of the defendant's position, filed a Motion for Summary Judgement. It is interesting to note that the plaintiff, sensing a lost cause, did not even bother to reply and the motion was granted. The hospital, a second defendant in the case, was dismissed and the case was closed.

Editor's Note: To further serve our members this year, the Journal of the Arkansas Medical Society has added a loss prevention column as a regular monthly feature. Case study articles will be rotated between the State Volunteer Mutual Insurance Group, The Medical Protective Company, The St. Paul Companies, and American Physicians Insurance Exchange. The intent of the column is to help physicians understand where, how and why things go wrong with physician/patient relations and how to protect themselves from similar problems.



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An Evaluation of Ethical Decision-Making

Andrew J. Lueders*

In the past 35 years science has exploded with new technological advancement in the area of medicine - advancements which often times can prolong life. A frustrating aspect of science, however, is that it often presses on with little consideration of the ethical implications of its discoveries. "When scientific projects race ahead of ethical reflection, we see decisions based on pragmatic grounds and immediate interests and concerns. Although technological accomplishments can give ethics the slip for a while, sooner or later they will meet up and settle accounts..."[1] Questions arise, for example, what does one do about the irreversibly comatose patient? Does *can do* mean *should do*? These questions address the present-day problems facing health care personnel who must confront this and many other ethical dilemmas.

"A dilemma is a situation requiring a choice between at least two alternatives that are equally compelling and for which we can make equally strong cases."[2] When it comes to present-day health care, there is no longer a time when right is right and wrong is wrong!

The most difficult questions regarding ethical issues relate to life-threatening illnesses, terminal illnesses, and problems associated with newborns. The medical community is divided when it comes to the issue of the terminally ill patient and whether to withhold or withdraw medical treatment. In March 1988 the Council on Ethical and Judicial Affairs of the American Medical Association issued an opinion that stated that a physician may withdraw artificial nutritional support and hydration where adequate safeguards have been ensured. The statement was met with extreme controversy. Some physicians welcomed it; some, perhaps fearing liability lawsuits, were disappointed with it. This illustrates the controversial nature of one of the many ethical dilemmas facing modern medicine.

How is a physician to approach these dilemmas? This paper is an attempt to offer some clarification and support for those who bear the social responsibility of deciding which course of action to take in a particular situation. This discussion will not concentrate on any one issue but will attempt to provide a starting point to assist in the evaluation of any one of today's ethical dilemmas. Two primary considerations will be examined: 1) who are the participants in decision-making, and 2) which ethical principles are helpful in determining a particular decision.

" The Good Samaritan story serves us well in individual one-on-one encounters, but it is silent with regard to issues of health care distribution. "

Participants in Decision-Making

Whose right to decide is it? This question addresses the problem of determining who the participants are in the decision-making process of a particular issue, i.e., whether to prolong or forgo treatment of an irreversibly ill patient. What role doe the patient play? The physician? The family?

In present-day relations between patients and physicians the competent patient is considered to be responsible for whether a particular course of action is accepted or rejected. The key descriptive term is competent. To be competent a person must have the ability to comprehend relevant information, to reason and deliberate, and also, to choose in the light of some goals and values and communicate that choice.[3] In some circumstances, involving serious illness or mental defect, a person is determined to be incompetent and incapable of making a decision. In these situations a living will helps the medical care-giver determine and act according to the desires of the patient expressed prior to illness. In cases where no living will is available, a durable power of attorney may be established. This proxy appointment authorizes someone, often a family member, to make treatment decisions on behalf of the patient.

Neither the living will nor the durable power of attorney is always able to perfectly represent the desires of the patient. In spite of their shortcomings, however, they are

Mr. Lueders is a sophomore medical student at the University of Arkansas for Medical Sciences. This paper was written during his CO-STEP experience at the Area Health Education Center, Northwest during the summer of 1989.

very helpful in trying to determine which course of action that patient would prefer.

Ethical Principles

In real life situations physicians must formulate a pragmatic approach to decision-making. Often, there is no single option or one right choice. In these situations four ethical principles are frequently employed to arrive at a particular decision.

The first principle is beneficence - that is, to do good and not harm. "The Hippocratic maxim states: Be of benefit and do not harm."[4] The physician is obligated to use professional skills to diagnose the patient's condition and then to recommend a course of action that is considered to be the best approach for that patient.

A second principle used in decision-making is autonomy. This principle was expressed by John Stuart Mill, among others, who said, "The individual is sovereign over his independence, his body, and his mind."[5] Each individual patient has the right to determine his or her medical treatment. "That right,grounded in both common law and the constitutional right privacy, includes the right to refuse life-sustaining treatment."[6]

A third principle is justice. Justice asks the question, what is the best allocation of a limited amount of resources? Today, health care planners are asking whether it is right to fund major organ transplants for a few persons or to provide basic health care to many. The issue in question is not benevolence, but justice and fairness. "The Biblical account of the Good Samaritan encourages altruism, benevolence, and compassion. The story serves us well in individual one-on-one encounters, but it is silent with regard to issues of health care distribution."[7] In today's world a physician must realize that everything done in medicine necessarily prohibits the doing of something else.

Justice can be evaluated from various perspectives: 1) a just decision is one that provides the most net benefit to the greatest number of people, 2) a just decision protects the distribution of health to those who, through hard work, are entitled to a high standard of health care, 3) a just decision requires society to use its resources to provide maximum care to those who have the greatest need, and 4) finally, a just decision provides treatment in order that the net welfare of all persons remains equal.[8]

The principle of justice is generally ranked behind benevolence and autonomy in priority. It does, however, play an important part in the outcome of a particular decision.

"The individual is sovereign over his independence, his body, and his mind."

"Although technological accomplishments can give ethics the slip for a while, sooner or later they will meet up and settle accounts..."

A final principle employed in ethical decision-making is utility, which holds that our actions should contribute to the greatest good of the greatest number of people. "This principle asks persons to evaluate whether and to what extent burdens and benefits accruing to persons, other than the patient, should be relevant or decisive in clinical decisions regarding the patient."[9] This principle, like justice, carries less weight than the first two principles, yet it does force the decision-maker to evaluate how and to what extent the interest of others should influence a particular course of action.

These four principles provide a means by which a physician may attempt to evaluate all the significant factors involved in a particular decision. A problem can be confronted most easily when an empathetic physician works supportively with an informed, competent patient. By understanding these principles a physician is better prepared to assess the patient's, as well as his own, desires and to make an appropriate decision.

Modern medicine is filled with many controversial and complicated issues. As technology continues to expand, further disagreement is inevitable. This paper is an attempt to outline some of the considerations that arise when contemplating what to do in a particular ethical dilemma. The evaluation is not intended to address all issues involved or to argue or defend any particular viewpoint but to provide a basic framework which may assist health care providers in evaluating present and future medical dilemmas.

Acknowledgement

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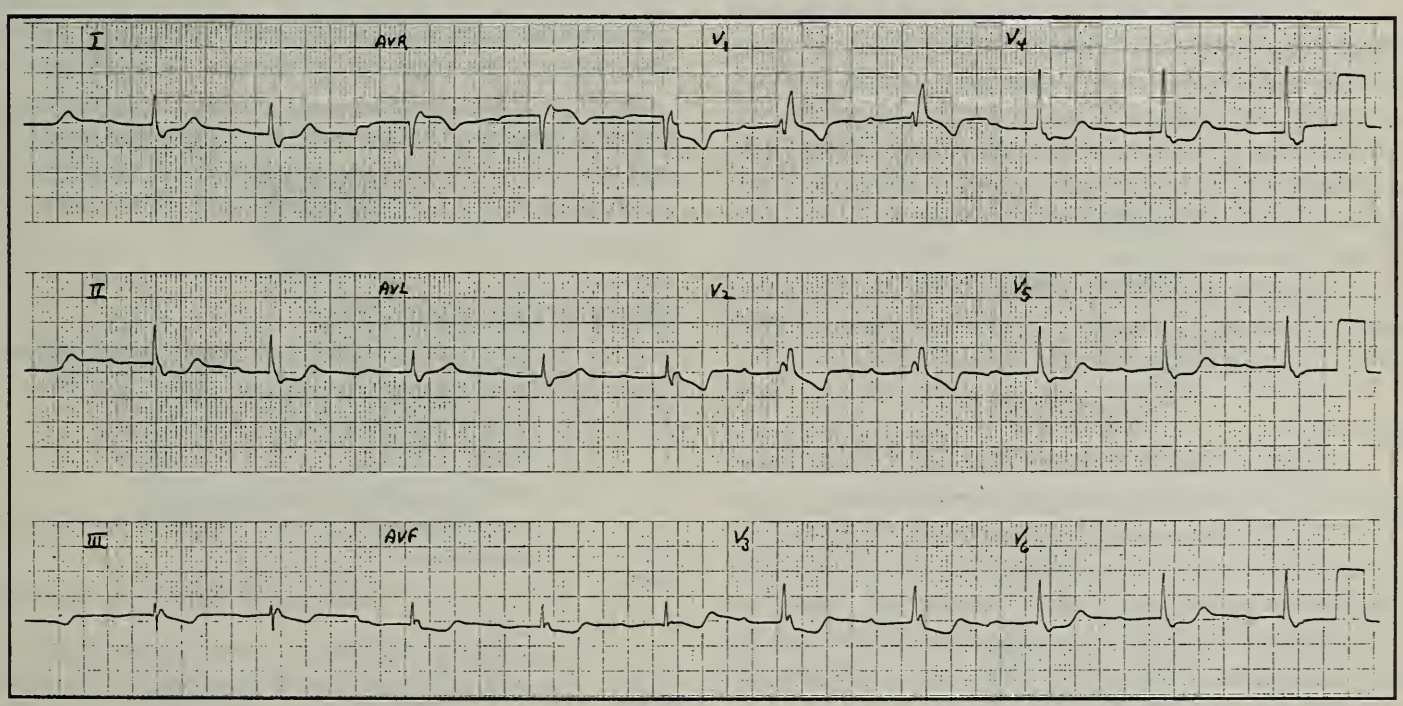


ELECTROCARDIOGRAM of the MONTH

William C. Furlow, M.D.
John W. Watson, M.D.
UAMS Division of Cardiology
Little Rock, Arkansas

CLINICAL HISTORY:

D.L is a 96-year-old lady who experienced a syncopal episode which resulted in a fractured hip and skull. Her cardiac examination revealed a soft first sound and increased but physiologic splitting of the second heart sound. What do you think of her ECG?



DISCUSSION:

The trace shows sinus rhythm with first degree AV block and right bundle branch block. Additionally, ST depression with a negative slope to the ST segment is noted in the inferior and lateral leads. Ischemia is suggested by the ST change. One could speculate as to the presence of significant impairment of conduction in the His to ventricular portion of the conduction system and give consideration to referral of the patient for electrophysiologic study, especially if no other explanation for syncope is manifested. the auscultatory findings are explicable by the electrocardiographic findings.

The editor wishes to thank Dr. Furlow of Conway, Arkansas, for his assistance with this month's featured electrocardiogram.

Fax, the Tool of Efficiency

Caren Crossland*

"Fax" has become as common a word in the business industry as "stat" is in the medical field. A facsimile sends information digitally through the phone lines to be printed in copy form by the receiving fax.

The first network of facsimiles were developed in Europe mainly to transmit photographs. During World War I the military used a fax to transmit maps, weather conditions for flight schedules and orders from top officials. It is estimated that in 1991 there will be over 2.7 million facsimiles installed, more than three times the number installed in 1987.

How Can a Fax Work for You?

Hospitals

Hospitals have always had the most high tech and accurate equipment for medical uses, but only recently have hospitals been adding fax machines to their business procedures. Several hospitals in Arkansas have gone on-line with fax this year. Jeff Roper, of Conway Regional Hospital, saw fax machines as a great time saver for his nurses stations, lab, emergency room and pharmacy. Roper said that the pharmacy has been able to fill prescriptions faster by fax because they don't all come in at once. Baptist Medical Center has recently made a decision to use facsimile machines and should be on-line by January 1, 1990, according to Terri McClure, Assistant Director of Communications.

Pharmacy

A study a Lowell General Hospital, Lowell, determined that trips to the pharmacy by nurses fell from 13.25 per day to 2.25 after they installed fax machines. Therefore, the pharmacy could receive prescriptions from the nurses by fax and have them processed in order of importance. Pharmacy records require exact copy of a written prescription with the doctor's signature. This can't be done with a computer, but it is possible with a fax.

Nurses Stations

Nurses can fax patient information and charts when moving patients from station to station. They also find it convenient to change dietary orders by faxing menus to the cafeteria for patient meals.

Laboratory

When working within the hospital network it is often necessary to have lab results as soon as possible; hence, the facsimile can drastically eliminate the transfer time now made on foot by hospital staff.

Record Transfers

Many hospitals use fax to send follow-up information requested by doctors and insurance companies, thereby accelerating payment of accounts. Soon hospitals will send patient medical records to doctors and clinics rather than using a local courier or cab.

Clinics and Private Practice

Just as hospitals fax to labs and pharmacies so can the physician in private practice. The clinic can make filling a prescription much more convenient for the patient by faxing the order to the requested pharmacy. Obstetricians and cardiologists have purchased fax machines for their homes to monitor patient's charts and strips without making a trip to the office. A fax can be a wonderful tool in any medical profession and is highly recommended for increasing productivity and efficiency.

Tips on Buying a Fax

When buying a facsimile there are several questions you should ask yourself:

1) How often will you use a fax?;
2) What size originals will you send?
3) Will you send pictures or graphs?
4) Will you send the same information to numerous locations?
5) How much space do you have for a facsimile?

Most brands of facsimiles work somewhat that same way. The sizes and prices vary and can range from $800 for $50,000 for business grade facsimiles. It is always smart to purchase office equipment with the future in mind. Never underbuy. When deciding on a fax machine make sure it is "user friendly." An elaborate piece of equipment has a tendency to make people timid when learning how to use it properly. It is a special treat when your dealer offers training and support to you and your staff. If training isn't offered upon purchasing a fax, don't hesitate to ask for some help.

Some of the features listed below are things you should look for when shopping for the right fax for your needs.

* Public Relations Coordinator, Business World, Inc., Little Rock, Arkansas.

Copy Quality

The resolution of print is often determined by three factors: 1. The sharpness of print on original; 2. Sending of halftones - pictures and graphs; and 3. Noise interference on the phone lines. Most facsimiles have a contrast control to allow different types of originals to be sent with sharp and clear resolution.

Printing Quality

A thermal transfer is the most common and inexpensive method of receiving. Plain paper and laser fax machines are the newest units on the market, but are still too expensive for most small volume users. Keep in mind a thermal processed document is not a permanent copy and may discolor or fade with time.

Automatic Paper Cutter

Imagine coming into the office to find a scroll of paper (20 or so documents) on the floor and have to hand cut each one into eleven inch sheets. In a medium to high traffic office it is often necessary to purchase a fax with the paper cutting feature. Most fax machines can be programmed to receive documents of all lengths, cutting between pages.

Document Feeder Capacity

Stackability will vary in models from 1 to 50 sheets. A 10-sheet document feeder will usually suit all applications for the small to medium volume user. A 30-sheet feeder may be advised for higher usage.

Broadcasting

It is vital to choose a fax with this feature if you intend on faxing the same information to multiple locations. This allows the operator of the fax to feed the documents into memory rather than placing them in the feeder several times to be sent, thus saving time and effort. This feature and the others described previously are common on most facsimiles.

Conclusion

The selection of your fax machine should be determined by the applications intended. Do not compromise when making this decision - the facsimile is here to stay.



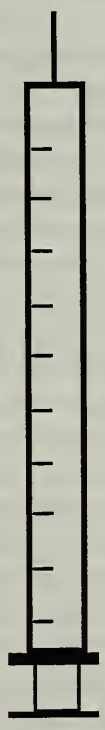
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The Mandatory Motorcycle Helmet Law Issue in Arkansas: The Cost of Repeal

Charles A. Rollberg*

When actor and motorcyclist Gary Busey failed to wear a motorcycle helmet and sustained injuries from a single-vehicle motorcycle accident in California in December 1988, the issue of motorcycle helmet safety made national headlines. Unlike so many riders involved in motorcycle accidents, Busey survived this life-threatening experience and has almost fully recovered in a relatively short period of time.

Many non-helmeted motorcyclists involved in accidents are not as fortunate as Busey. The Federal Accident Reporting System in 1987 reported 3,831 motorcycle occupant fatalities.[1] Of these fatalities, 1,989 or 52% were not wearing a helmet at the time of accident, 1,415 or 37% were wearing a helmet, and 427 (11%) helmet usage was unknown. A Louisiana study[2] concluded that head injuries sustained by motorcyclists are the primary cause of death in 55% of motorcycle fatalities. These statistics provide compelling evidence that motorcycle helmets do prevent serious injury and death resulting from motorcycle crashes.

The National Accident Sampling System in 1986 estimated that 148,000 occupants of motorcycles survived injuries related to motorcycle accidents.[3] Of the survivors, approximately 63% were wearing helmets at the time of the accident, 30% were not, and 7% helmet usage was unknown.

Less than two months after the well-publicized Busey accident, the 77th Arkansas General Assembly convened in January, 1989 to consider, among other things, whether to repeal the state's existing mandatory motorcycle helmet law. Lawmakers heard from motorcycle enthusiasts like Busey who refuse to wear motorcycle helmets and from public and private individuals who support the existing law. On February 13, the Arkansas Senate voted 21-12 in favor of repealing the mandatory helmet law. Then on February 28, after hearing testimony from both sides, a house sub-committee voted against repealing the mandatory helmet law.

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The purpose of this article is to examine the impact of repealing the Arkansas mandatory motorcycle helmet law. In order to assess its impact, some knowledge of prior helmet legislation, research conclusions regarding demographic and medical characteristics of injured motorcyclists, and information about costs of motorcycle injury is needed. The Louisiana study[2] will serve as a basis for estimating expected motorcycle fatalities and injuries. This information will be applied to Arkansas data to determine the impact of repealing the existing mandatory helmet law.

History of Motorcycle Helmet Legislation

Research conducted on the efficacy of motorcycle helmets has shown that helmets significantly reduce the chances of death and disability to riders.[4,5] As a result of the knowledge gained by the research, Congress in 1966 passed legislation that would allow for federal funds to be withheld from states that failed to enact mandatory motorcycle helmet laws.[4-6] Many states were forced to enact helmet legislation or run the risk of losing federal highway funds.

Following the federal legislation of 1966, 47 states, including Arkansas, enacted some form of a mandatory motorcycle helmet law by 1975.[4] Between 1966 and 1976, motorcycle related fatalities decreased nearly 57% from 11.5 deaths per 10,000 motorcycles to 5 deaths per 10,000 respectively.[6] While helmet laws were responsible for decreased motorcycle fatalities, they were also responsible for increased anti-helmet lobbying efforts.[7]

As states enacted mandatory helmet laws, political pressure from motorcycle organizations and civic groups such as the American Civil Liberties Union was directed at state legislatures.[6] Anti-helmet lobbying efforts were based on claims that motorcycle helmets contributed to increased injuries and that mandatory helmet laws were an infringement of personal rights of motorcyclists.[6] Because of the effectiveness of anti-helmet lobbying groups, Congress in 1976 amended legislation that withdrew the authority of the federal government to withhold highway funds from non-compliant states.[4-6]

Table I. 1987 Nationwide Motorcycle Fatalities by Age and Helmet Usage

Age	Helmeted	Non-Helmeted	Unknown	Total
0-10	1	4	1	6
11-20	357	488	83	928
21-30	643	929	207	1,779
31-40	264	405	87	756
41-50	94	115	30	239
51-60	34	36	8	78
61-70	16	9	8	33
71>	6	3	3	12
Total	1,415	1,989	427	3,831
% of Total	36.9%	52.0%	11.1%	100%

Source: U.S. Department of Transportation, National Highway Traffic Safety Administration, Federal Accident Reporting System, 1987.[1]

The aftereffect of the 1976 amended legislation removed the ability of the federal government to penalize non-compliant states. With the penalty of losing federal highway funds removed, states were free to succumb to political pressure from anti-helmet groups, and succumb they did.[7] By 1980, state legislatures in 28 states either repealed or weakened their mandatory motorcycle helmet laws.[8] Hartunian, et al. estimated that 516 excess deaths occurred in 1980 alone as a consequence of this massive repeal at an economic cost to society of approximately $180 million.[8]

In 1967, Arkansas enacted a mandatory motorcycle helmet law. Arkansas code 27-20-104 requires all "passengers and operators of motorcycles and motor-driven cycles used upon public streets and highways"...shall be equipped with protective headgear as set forth by the Office of Motor Vehicle of the State of Arkansas.[9] As the 77th Arkansas General Assembly convened in its 1989 regular session, new legislation was introduced to repeal the existing helmet law.

In 1989, Senate Bill 43 was introduced to repeal Arkansas' existing mandatory helmet law. On February 13, 1989, the Arkansas Senate voted 21-12 in favor of repealing the helmet law. Later that month, a House of Representatives sub-committee, after hearing public testimony from both sides, voted by acclamation to kill Senate Bill 43.

While the sub-committee's reasoning for killing Senate Bill 43 is not known, their actions may well have saved the lives of motorcyclists.

Demographic and Medical Characteristics of Injured Motorcyclists

Motorcycle fatalities and injuries are common across the United States. Data compiled by the Federal Accident Reporting System (FARS) indicate that 3,831 motorcycle fatalities occurred nationally in 1987.[1] Of these fatalities, 70.8% were under the age of 31 and nearly 97% under the age of 51. Males and females represented 92% and 8% of the fatalities, respectively. Table I identifies motorcycle fatalities by age and helmet usage in 1987.

As Table I indicates, helmeted motorcycle fatalities occurred 36.9% of the time, non-helmeted fatalities 52%, and fatalities where helmet usage was unknown was 11.1%. Additionally, fatalities occurred more often in the 21-30 age group, nearly twice as much as the next most frequent fatality age group of 11-20. These demographic characteristics of motorcycle fatalities are similar to characteristics of motorcycle injuries.

The National Accident Sampling System (NASS) estimated that approximately 148,000 occupants of motorcycles were injured and survived in 1986.[3] Of the 148,000 estimated injured survivors, nearly 91% were male. Further, 88% of these injured males were under the age of 35. Females represent more than 9% of injured survivors with approximately 91% of them under the age of 35. Injured

Table II. Arkansas Motorcycle Fatalities and Injuries by Year and By Helmet Usage 1984-1988

		HELMETED				NON-HELMETED			
Year	MC Reg.*	Fatal.	Rate#	Injuries	Rate+	Fatal.	Rate#	Injuries	Rate+
1988	17,327	9	.519	75	4.329	22	1.269	655	37.802
1987	20,048	11	.549	157	7.831	33	1.646	886	44.194
1986	24,048	13	.539	215	8.929	15	.623	907	37.669
1985	28,886	6	.208	156	5.400	29	1.004	1,150	39.812
1984	28,161	4	.142	122	4.332	27	.959	1,247	44.281
Total	118,500	43		725		126		4,845	
Mean			.362		6.164		1.063		40.886

* Represents the number of motorcycle registrations in Arkansas
\# Represents the rate of fatality per 1,000 motorcucle registrations.
\+ Represents the rate of injury per 1,000 motorcycle registrations.

Source: Arkansas Department of Finance and Administration[20]

Table III. Louisiana Motorcycle Fatalities and Injuries 1976-77 and 1981-82

Year	MC Reg.	Fatal.	Rate	Injuries	Rate
RE-ENACTMENT PERIOD					
1982	109,300	92	.842	1,565	14.318
1981	92,600	132	1.425	2,351	25.388
REPEAL PROCESS					
Year	MC Reg.*	Fatal.	Rate#	Injuries	Rate+
1977	66,158	92	1.390	2,491	37.652
1976	58,130	64	1.100	1,931	33,218

* Number of motorcycle registrations in Louisiana
\# Represents the rate of fatality per 1,000 motorcycle registrations
\+ Represents the rate of injury per 1,000 motorcycle registrations.
Source: McSwain NE, Willey AB.[2]

survivors between the ages of 20-24 account for nearly 40% of total injured survivors.

Studies that examined motorcycle related injuries found conclusions similar to those indicated by the FARS and NASS data.[4,6,10-12] In these studies, males represented 79% to 97% of the injured motorcyclists. The average ages of those injured range from 22 to 28.6 years. Injuries sustained from motorcycle accidents often required hospitalized care. The average hospital stay of those injured ranged from 13[11] to 22[10] days. Bray, et al noted that 55% of those sampled were legally intoxicated according to blood alcohol levels taken at time of hospital admission as defined by California law.[12]

Arkansas, too, has several motorcycle related fatalities and injuries occurring annually. Data obtained from the Arkansas Transportation Safety Agency indicate that 31 motorcycle related fatalities were reported in Arkansas in 1988.[13] Of these fatalities, nearly 71% were non-helmeted, 29% were helmeted, and 77.4% were under the age of 35. The age groups of 21-24 and 25-34 represent the most frequent age of motorcycle fatalities with 19.4% and 25.8% of total fatalities occurring in these groups, respectively. Additionally, 730 motorcycle occupant injuries were reported in Arkansas in 1988. Almost 90% of those injured were non-helmeted, 10.3% were helmeted, and 88.6% were under the age of 35.[13] Table II identifies motorcycle fatalities and injuries by year and by helmet usages and calculates a fatality and injury rate per 1,000 motorcycle registrations.

As Table II indicates, nearly three times as many non-helmeted than helmets fatalities occurred, while almost seven times as many non-helmeted than helmets injuries occurred in Arkansas from 1984-1988.

Louisiana Motorcycle Helmet Study

The Louisiana legislature, like Arkansas, enacted a mandatory motorcycle helmet law in the late 1960s.[2] but unlike Arkansas, Louisiana repealed its motorcycle helmet law in 1976, as many states did. Following the repeal of the helmet law, motorcycle fatalities increased by 44% in Louisiana.[2,15] Then in 1981, Louisiana because the first state to re-enact a mandatory motorcycle helmet law for all motorcyclists.[2] This set of events, the repeal and the re-enactment of the helmet laws, established an excellent opportunity for measuring the impact of a mandatory helmet law versus a non-mandatory helmet law. There are several important conclusions from the Louisiana study that are pertinent to this analysis.

One of the most important findings of the Louisiana study was that with the repeal of the helmet law, motorcycle fatalities increased nearly 44% and with the re-enactment of the law, fatalities declined more than 30%. Second, when the non-mandatory helmet law was in effect, fatal head injuries occurred twice as often than when the mandatory helmet law was in effect. Third, head injury was cited as the most common cause of death 55% of the time. Finally, helmet usage increased from 46% to 72% at a minimum as a result of the mandatory helmet law.[2,15]

Other studies support the findings of the Louisiana study.[5,15,16] Watson et al examined 26 states that repealed or weakened their motorcycle helmet laws and concluded a 38% increase in the motorcyclists fatality rate.[5] Dart et al concluded that motorcycle fatalities increased by 45% in Louisiana and that helmet usage decreased by 50% following the repeal of the helmet law in 1976.[15] Table III identifies Louisiana's fatality and injury rate per 1,000 motorcycle registrations for the 1976-77 repeal period and the 1981-82 re-enactment period and calculates a corresponding rate of change for registrations, fatalities, and motorcycle injuries.

As Table III indicates, the fatality and injury rates per 1,000 motorcycle registrations increased 26.4% and 13.3%, respectively, following repeal of the helmet law in Louisiana. With the re-enactment of the helmet law, the fatality and injury rates per 1,000 motorcycle registrations decreased 41.1% and 43.6% respectively, in spite of an 18% increase in motorcycle registrations.

Table IV applies the findings of the Louisiana study to Arkansas data for 1988. As Table IV indicates, Arkansas

Table IV. Expected Arkansas Motorcycle Fatalities and Injuries After Repealing the Motorcycle Helmet Law

Year	MC Reg.	Fatal.	Rate	Injuries	Rate
1988	17,327	31	1.789	730	42.13
1988*	17,327	39	2.260	827	47.75
Change		+8	+26.3%	+97	+13.34%

* These data represent expected values of motorcycle fatalities and injuries in Arkansas based on changes found in the Louisiana study as a result of repealing their mandatory helmet law.
Source: Arkansas Department of Finance and Administration[20]

could expect an increase of 8 fatalities and 97 injuries as a result of repealing the helmet law, assuming accident trends in Arkansas closely parallel those trends identified in Louisiana.

Cost of Motorcycle Injuries and Who Pays?

When motorcyclists sustain fatal or non-fatal injuries resulting from a vehicular crash, many types of costs are incurred by the injured or the injured's estate. The purpose of this section is to examine the general cost components and cost types associated with "cost of illness" or motorcycle injury data, to cite previous research findings regarding cost of motorcycle injury, to identify who pays for these costs, and finally to apply these cost findings to Arkansas data.

Whether we concern ourselves with costs associated with a tonsillectomy, a pulled wisdom tooth, or injuries sustained in a motorcycle crash, all of these costs refer to "costs of illness." Studies classify cost of illness in three general categories of direct, indirect, and psychosocial costs.[17,18] Within each general cost component category are type of costs associated with a specific service. For example, initial hospital care is a cost type associated with direct cost. The loss of earnings due to sickness or death is a cost type associated with indirect costs. Indirect costs are usually stated in present value and discounted by some social discount rate ranging from 6% to 10%. The stress or pain and grief an individual may feel as a result of a motorcycle crash are examples of types of cost associated with psychosocial cost. Table V classifies a partial list of cost of illness by cost component and by type of cost.[19]

Table V. Costs of Illness Classification

Cost Component	Type of Cost
Direct Cost	
a. **Health Related**	
	Emergency Care
	Initial Hospital care
	Physician and Surgeon services
	Rehabilitation care
	Nursing home or home health care
	Drugs, medical supplies
	Outpatient care
	Rehospitalization
	Insurance administration
b. **Non-Health Related**	
	Home modifications
	Transportation costs to providers
	Retraining and re-education
	Legal expenses
Indirect Cost	
	Earnings losses due to sickness or death
Psychosocial Cost	
	Loss of body part, motor, mental skills
	Pain and grief
	Stress of undesired life adjustment
	Family conflict
	Divorce, suicide, or anti-social behavior

Source: Muller A, Rollberg C, Wayne, J.[19]

Considerable research has focused on cost of illness as related to motorcycle injury.[4,8,10,12,16,18] Some research has focused on cost of illness of motorcycle injury as it relates to repealing helmet laws.[8] For example, Hartunian et al estimated that the massive repeal of motorcycle helmet laws in the late 1970s cost society $180 million (these were 1980 dollars). This amounts represents direct and indirect costs incurred by society as a result of increased fatalities and injuries related to motorcycle crashes in states that repealed mandatory helmet laws.

Most of the studies reviewed for this paper restrict their cost analyses to direct costs only and do not quantify indirect or psychosocial cost. The average hospitalization cost of motorcycle trauma ranges from $15,114[10] to $25,764.[4] Variations in the numbers may be attributed to differences in sample size, the location of the study, the time period the study was conducted, and the measurement of different types of costs. Additionally, the dollar amounts represented are actual dollars not adjusted for inflation.

One study determined direct and indirect costs of motorcycle trauma.[4] Rivera et al studied 105 hospitalized motorcyclists for a 20-month period. Total direct costs for these patients totaled more than $2.7 million or an average cost of $25,764. Indirect costs for these patients were based on employment data from 44 individuals. The study calculated conservative indirect costs for fatalities at $2.4 million or an average of $353,967 per motorcyclist and indirect costs for injuries at $1.9 million or an average of $443,735. Total direct and indirect costs are estimated at $7.1 million for 105 motorcyclists for a 20-month period.

A frequent argument made by motorcycle enthusiasts in favor of repealing helmet law is that the motorcyclists pay for the burden of injury. Studies indicate that this statement is inaccurate.[4,12] Bray et al found that 82.3% of acute hospitalization costs are paid from public funds. Rivera et al found that 56.3% of motorcycle injury costs are paid by state Medicaid funds, 7.1% from other public funds, 22.7% from commercial or self-pay sources, and 13.9% from unknown sources.

Table VI identifies average direct and indirect costs per motorcyclist for 1986 and 1988. Average indirect costs are stated in terms of fatalities or injuries. The appropriate cost to use is determined by whether the motorcyclist was injured or fatally injured. Further, these figures were applied to 1988 Arkansas data to arrive at average costs from two different perspectives: one showing costs under the current helmet law and the other showing costs if the present law were to be repealed.

As shown in Table VI, direct and indirect costs of additional motorcycle injuries would be expected to increase

Table VI. Average Direct and Indirect Costs of Motorcycle Injury by Year by Injury Status.*

Year	DIRECT	INDIRECT	
		Fatal	Injury
1986	$25,764	$353,967	$43,735
1988#	$27,880	$402,199	$49,693

Direct and Indirect Costs of Motorcycle Injury by Status of Helmet Regulation

	DIRECT	INDIRECT	TOTAL
With Helmet Law	$21,216,680	$48,743,718	$69,960,398
Without Helmet Law	$24,144,080	$56,781,443	$80,925,523

* Direct costs are adjusted by the medical care component of the CPI.[21]
\# Indirect costs are adjusted by wage and salary disbursements.[21] (p.414)
Source: Riveria FP, et al.[4]

in the event of repealing the existing helmet law in Arkansas. The expected increase in direct costs is $2.9 million, while expected indirect costs increased $8.03 million. The total expected increase of direct and indirect costs of motorcycle injury in Arkansas in 1988 would be $10.9 million.

Applying conclusions found in other studies,[4,12] the public could expect to pay a minimum of $1.7 million if the current law were repealed in 1988. This figure reflected only the public's share of direct cost payments. Plausibly, the public would also share some percentage of indirect costs by paying higher prices for goods because of losses in aggregate productivity or increases in compensation pay for injured motorcyclists.

Conclusion

Many motorcycles fatalities and injuries occur annually in the United States. In 1987, the Federal Accident Reporting System reported 3,831 motorcycle occupant fatalities. In 1986, the National Accident Sampling System estimated that 148,000 occupants of motorcycles survived injuries related to motorcycle accidents. Many of these survivors (63%) were wearing helmets at the time of the accident.

While research has shown the efficacy of motorcycle helmets in significantly reducing the chances of death and disability related to motorcycle accidents, anti-helmet lobbyists have pushed for non-mandatory helmet laws. In 1975, 47 states, including Arkansas, had some form of a mandatory helmet law. As a result of anti-helmet lobbying efforts, 29 states repealed or weakened their motorcycle helmet laws by 1980. Hartunian et al estimated that 516 excess deaths occurred in 1980 alone as a consequence of this massive repeal at a cost to society of approximately $180 million.

A Louisiana study identified trends of motorcycle fatalities and injuries when its mandatory helmet law was repealed and re-enacted. Using this study to project expected motorcycle fatalities and injuries in Arkansas, in the event of repealing the existing law, increases in the rate of fatalities and injuries per 1,000 motorcycle registrations would be expected. As a result of these increased fatalities and injuries, total direct and indirect costs of motorcycle injury in Arkansas in 1988 would increase $10.9 million. The public could expect to pay a minimum of $1.7 million additional dollars as a result of repealing the existing law. Is the freedom of riding a motorcycle without a helmet worth $10.9 million?

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The Pulaski County Medical Society's Executive Secretary

Gilbert Dean, M.D.*

Paul Harris was hired as the first full-time executive secretary of the Pulaski County Medical Society (PCMS) on July 1, 1961. John William Smith, M.D. was the society president and John McCollough Smith, M.D. was president during Paul's first full year of service. The society office was at 510 Pulaski Street in downtown Little Rock. At that time there were 315 active and life members in the society. Today there are 830. The office is now located at 311 Doctors Building.

The post World War II resurgence in the nation's economy was producing a social and industrial revival that has continued for forty-five years. Society Security, Medicare, and Medicaid were being established and are still much debated issues. Inflation and a persistent national budgetary deficit were becoming recognized as partners of our work trade deficit. The Dow Jones averages were beginning to soar from 100 to over 2,700 points. General Motors, Ford, and Chrysler were beginning the production of millions of beautiful new cars and trucks. Abbott, Geigy, Eli Lilly, Merck, Parke-Davis, Roche, Roerig, Searly, Squibb, Smith Kline and French, Upjohn, Wyeth, and other companies were developing hundreds of antibiotics, antiarthritics, antiacids, vasodilators, antihypertensives, beta blockers and many other aids to medicine.

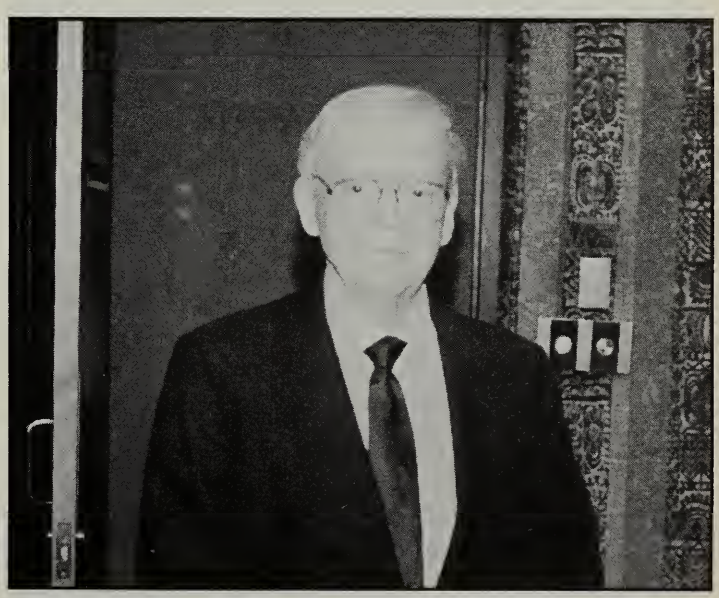
The Pulaski County Medical Society continued to be influenced by changes that few of its members could foresee. A growing University Medical Center increased the size of its full-time and part-time faculty as well as the number of medical school graduates. As the population in Pulaski County increased, the number of new physicians grew; and a fantastic increase in the variety of newer treatment modalities produced a vast increment in the grouping of medical specialties. Whoever heard of an oncologist, nephrologist, hematologist, a specialist on the retina, or an orthopaedist who replaced knee joints? HMOs, PPOs, medical advertising, and complete insurance coverage by the larger industries have changed the physicians' perspective. So have DRGs and PROs!

"When a man has ideals and is loyally devoted to realizing them, he inspires others. Such a person is Paul Harris."

Charles R. Henry, Sr. (1970)

This brief outline, which merely suggests the explosive changes affecting the vagaries of practicing medicine that have and are occurring, indicated how fortunate has been the Pulaski County Medical Society's choice of Paul Harris as its full-time executive secretary for twenty-eight years.

Paul has been like the "mother duck" herding and protecting the interests of the sometimes too many and diverse ducklings. During his tenure, twenty-nine society presidents have maintained a continual process of holding elections and selecting chairmen and members of twenty or so active committees in such a way that there has always been an attentive and powerful executive committee to debate and vote on the important business of the society.



Paul Harris has been the Executive Secretary for the Pulaski County Medical Society since 1961.

* Dr. Dean is a retired Pulaski County physician and a Life member of the Arkansas Medical Society. He was president of the Pulaski County Medical Society in 1967. He resides in Little Rock.

Multiple community organizations and many individuals have long recognized the secretarial office as the place to go to secure answers to problems related to securing reputable physicians for various and sundry purposes: part-time government work, second opinions, settlement of complaints, etc. Complaints are referred to the state medical board when warranted.

Publication of the accumulated and important data in the membership directory of the PCMS is handled by the secretary, also the writing, typesetting, and mailing of five PCMS bulletins a year. He oversees the collection of PCMS, AMS, and AMA dues for 830 members as well as maintaining the applications and files on all the members. There is the keeping of the books of the society, and handling (under the direction of the finance committee) the financial affairs of the society.

The secretary is responsible for taking, typing, and storing the minutes of the executive committee meetings and the society membership meetings. His responsibilities include helping select, notify, and instruct all delegates to the Arkansas Medical Society meetings. Assisted by the program committee, the secretary finds speakers and arranges programs for five membership meetings a year. This includes coordinating such arrangements as location of the meeting, table arrangements, menus, greeting of members and spouses, seating of speakers and special guests, securing audio-visual equipment, etc.

In 1963 the PCMS Exchange was established at Paul's suggestion and with society approval. The service rendered by the exchange has been exemplary. Various paging systems have been added to the telephone communication arrangements. Supervision of the exchange includes scheduling, staffing, payroll, purchasing, bookkeeping, finances, and upkeep on equipment and furnishings. The exchange employs seventeen operators and handles over 1,500 calls a day. The additional revenues produced by the exchange have made it possible to maintain a "no increase" in the yearly dues of the society, which were $60 in 1961 and 1989.

A continued reviewing of various insurance programs affecting the doctors has been done. Information is also provided to OCMS members on various matters such as the disposition of patient records, malpractice insurance companies, opening and closings of offices, and current issues in organized medicine.

The Senior Physicians of Arkansas organization was founded in April, 1984, with John McCollough Smith as its first president. Monthly meetings are held. Under the direction of the SPA president, Paul arranges all aspects of these meetings including agendas, programs, minutes, etc.

One memorable accomplishment of the society occurring under the leadership of president Robert Watson and committee chairman Jerome Levy, was the Polio Immunization Program in 1963. Paul coordinated a county-wide mass immunization program with the help of the PCMS Auxiliary and hundreds of volunteers. Over the course of several weeks, more than 300,000 individual doses of polio vaccine were administered. A subsequent anti-measles vaccine program was supervised and successful performed.

Paul has served on many committees and boards of various groups over the years. He was very active in the Rotary for many years. He taught a boys Sunday School class at Second Baptist Church for many years and is currently a member of Pulaski Heights Baptist Church. He served on the Arkansas Medical Society's Committee on AIDS and was previously on the board of the Visiting Nurse Association. He attends two AMA meetings a year to stay abreast of crucial issues facing PCMS members. Due to his always gracious availability, the PCMS women's auxiliary has come to regard Paul as almost one of their active members.

"I will forever remember him with a warm heart for his selfless untiring efforts. My summary of his role as the executive secretary was that he did his job exceedingly well."

Frank M. Westerfield, Jr. (1977)

Several of the twenty-nine doctors who have serves as president of the PCMS during Paul's tenure have submitted the following excerpted remarks:

W. Payton Kolb (1965): "He has done a fantastic job as executive secretary. As we all know the society has been efficient, well-organized, and has made a tremendous contribution to the community and to the Arkansas Medical Society with the diligent work of Mr. Harris. Certainly one of the major contributions has been his development and operation of the medical exchange. Here again his composure dealing with many divergent personalities has been remarkable."

Joseph D. Calhoun (1966): "Thanks for the opportunity to reflect back over the years to add my bit to the recognition that Paul so richly deserves. That his contributions went beyond the call of duty only enhances their value and I want to be counted among the many who appreciate the man and his work."

James L. Smith (1971): "He made himself available in advance of every decision or crisis, and never offered his opinion of a solution to a problem until the same was requested."

G. Thomas Jansen (1972): "I found Paul attentive, efficient, and responsive to the needs of the Pulaski County Medical Society. He has continued to serve in that fashion. I salute him on a job well done."

Purcell Smith, Jr. (1974): "I was honored to serve as President of the Pulaski County Medical Society in 1974. This was a pleasant experience, and to a great extent, the smooth operation of the country society was due to Paul Harris. On the numerous occasions when I requested his advice and assistance, he was willing and able to help me in any way possible. Paul was very attentive to details in planning for the various meetings. He was a good spokesman for the society and his manner and appearance gave a good impression for the Society."

Amail Chudy (1976): "His great gift of integrity will always be Paul's. Being around him is a learning process and he makes it fun. This unusual ambassador surely deserves a high place in the hereafter."

Frank M. Westerfield, Jr. (1977): "His acceptance of an endless need to prompt and remind me of my various duties was most effective and I will forever remember him with a warm heart for his selfless untiring efforts. My summary of his role as the executive secretary was that he did his job exceedingly well."

William N. Jones (1978): "I think I can say for all of our past presidents and others who have served in various leadership capacities that whatever we appeared to have accomplished was in no small measure the result of the total support, assistance and encouragement of Paul Harris. He has been my advisor, listener, consoler, confidant,and loyal friend throughout and without interruption."

"That day in 1961, when young Paul Harris became secretary to the Pulaski County Medical Society, is a day for which we all should have an everlasting appreciation. Time has shown that a better choice could not have been made, and time will be sorely taxed to ever find a better Executive Director."

Robert Watson, M.D. (1963)

W. Ray Jouett (1980, 1982): "He exhibits a tremendous amount of enthusiasm for what he does and he is able to convey this to members of the Pulaski County Medical Society and especially to the executive committee. I also found him to be nothing but totally and completely honest about any project or about any problem that must be dealt with in the county society. Another outstanding quality was that of loyalty which he displays constantly."

Charles W. Logan (1981): Mr. Paul Harris has accomplished a yoeman's job magnificently and we, the members of the Arkansas Pulaski County Medical Society and our wives of the Auxiliary of the Pulaski County Medical Society, are deeply indebted to this wonderful man."

Kelsy J. Caplinger, M.D. (1983) - "It is always interesting to note the wealth of information that has accumulated in Paul's head regarding the Pulaski County Medical Society through the years. He has certainly been a valuable asset and vital to keeping the County Society together through the years."

Harold D. Purdy (1984): "This is a very dedicated man; he has been synonymous with Pulaski County Medical Society for many years."

Warren M. Douglas (1985): "My problem is in finding enough good things to say about him. Mr. Harris took care of the medical society business in a professional, efficient, and pleasant way. He has an encyclopedic knowledge of medical society business. His pleasant and quiet demeanor, his accommodating attitude...made it a genuine pleasure to work him."

Fred O. Henker, III (1986): "He was the most congenial person I've ever had the pleasure of working with - calm, never ruffled, always ready with guidance and assistance presented in such a manner as to give me personal satisfaction while reserving none for himself. Paul was readily accessible. Nearly always he was immediately on the phone; if not, he returned my call within minutes.

Carlos A. Araoz, current PCMS President: "My hope is that his performance will be a standard of excellence of service for organized medicine. I believe that this tradition would be invaluable for the benefit of future generations of patients and physicians of Arkansas."

In 1961, at age 38, Paul attended Little Rock University and Southern State College in Magnolia, Arkansas. He worked for the Pulaski County and Arkansas Tuberculosis associations for eight years. He is married to Bobbie Langston from Drew, Arkansas, and they have two sons, Ray and John.

Paul's father, Ernest Hugh Harris, was a country doctor and a graduate of the Little Rock College of Physicians and Surgeons. He practices in Coy, Arkansas, where Paul was born. Something in Paul's background or in his innate ability has served him well for the past 28 years as the Pulaski County Medical Society's only full-time secretary and guardian.

Breast Cancer Metastatic to the Lung

Jacob Amir, M.D., William E. Atkinson, M.D., James E. McDonald, M.D., Harold D. Langston, M.D., and Ms. Harriet Farley, M.S.W.*

A 36-year-old female noted a mass in her right breast and had a mammogram which was said not to be suggestive of malignancy. She returned for a followup after the mass increased in size. A biopsy was done and a 3 cm lesion was removed that contained infiltrating ductal carcinoma. A modified radical mastectomy was done. The patient is premenopausal and hormone receptor studies revealed less than 3 ER and less than 3 PR. Aggressive chemotherapy was suggested and accepted by the patient. She was closely followed and after complaining of sensation on deep breathing, was discovered to have bilateral lung metastases. She presented to the panel for an opinion as to the efficacy of chemotherapy and her prognosis.

Pathology Review

Dr. Atkinson: The right breast tumor was an infiltrating ductal carcinoma. Eight of the twenty-two lymph nodes contained metastatic disease. The lung biopsy showed metastatic cancer consistent with adenocarcinoma of the breast.

Radiology Review

Dr. McDonald: The original mammogram was unavailable. The original x-ray of the chest shows no disease. There was a negative bone scan. The chest x-ray that was taken after she complained of sensation on deep breathing shows bilateral metastatic disease. The followup x-ray show some shrinking of the tumor. The last chest films available show the original nodules as stable and what appears to be miliary spread of the tumor. This appearance could also represent superimposed infection.

Radiotherapy Review

Dr. Langston: The spread of the tumor in the lung and its size would rule out the use of radiation. It is possible that radiation could be used for pain control, if the disease spreads.

Oncology Review

Dr. Amir: The drugs that have been used in the chemotherapy are appropriate as is the aggressive approach that has been taken to this tumor. There are other drugs that could be used, if these drugs are not effective.[1] The reports seem to indicate that the chemotherapy was shrinking the tumor, but that the tumor is now growing. The approach to this would be to change the chemotherapy. This, as I understand, has been recommended. Because of the patient's fever and night sweats, it is important to rule out infection.

I also understand that the patient wants to go to an out-of-state cancer center for their opinion. All of us encourage this. There may be experimental protocols that would be available there. The patient should realize that she could return to Arkansas and receive the chemotherapy required by the protocol here, if she so desired. Also, the pain that the patient is experiencing in her back can and should be controlled. She should not be kept awake by pain.

Consensus

The second opinion panel reviewed the clinical findings, radiographs, histopathology, and treatment protocol. The panel was in full agreement with the histopathologic diagnosis, the radiographic findings and chemotherapeutic treatment. There were two questions posed. One had to do with the origin of the lower back and sciatic type symptoms the patient had been having. The MRI of the lumbar was negative for herniation, although muscle entrapment of nerve could not be definitely ruled out. In addition, it was pointed out that microscopic tumor could be present in this area but could be too small to be demonstrated. Repeat MRI and bone scans would be indicted to followup this problem.

The apparent purpose of the second opinion was regarding continuation of chemotherapy. The panel re-

St. Vincent Cancer Center, St. Vincent Infirmary Medical Center, Two St. Vincent Circle, Little Rock, Arkansas 72205.

viewed the x-rays. There did appear to be a considerable improvement with diminution in the size of the lung nodules between the time of their discovery in early May, 1989, up until the repeat chest film in June, 1989. The films in July, 1989, revealed a miliary type pattern but there still seemed to be resolution of the larger nodules. The panel questioned whether or not this miliary pattern indeed represented tumor. In view of the history of fever and recent night sweats, the panel felt there was a strong possibility that the most recent change in the chest film represented inflammatory rather than neoplastic disease.

The panel encouraged the patient to followup on her plan to visit the M.D. Anderson Hospital in Houston. The panel felt that her oncologist would help in every way necessary to expedite the consultation in Houston. The patient was told that there was a good chance that after being seen in Houston, their recommendation would be for continuation of chemotherapy by the oncologist in Little Rock. This would depend in large degree upon whether or not the recent x-ray findings represented inflammatory or malignant change. This would most certainly be established before a decision about the chemotherapy could be made.

The panel felt that the persistence of pain was certainly a problem and that a change in medication or dosage was indicated for pain control.

Following the panel discussion, the patient and family members met with the oncology social worker.

References

1. Bennett JM, Muss HB, Doroshow JH et al. A randomized multicenter trial comparing mitoxantrone, cyclosphosphamide, and fluorouracil with doxorubicin, cyclophosphamide, and fluorouracil in the therapy of metastatic breast carcinoma. J Clin Oncol 1988; 6:1611-20.

Winona, MS. - Family Practice, Surgery, Internal Medicine, OB/GYN, Pediatrics. Excellent quality of life, exceptional public school system. Sumner Scholarship Grant for college tuition. Crossroads of I-55 and Highway 82, 88 miles to Jackson, 110 to Memphis. Recruitment package available. Contact Richard Manning, Administrator, Tyler Holmes Memorial Hospital, Tyler Holmes Drive, Winona, MS 38967, (601) 283-4114.

EASTERN ARKANSAS - Partnership opportunity available in community of 14,000 near Memphis. Beautiful JCAHO approved 120-bed hospital with excellent staff. Current Orthopedist very busy and willing to provide excellent financial package with option of buy in or association. Interviewing expenses and relocation costs paid. Contact Jeff Hartline, 5000 Linbar Drive, Suite 260, Nashville, TN 37211, 800/678-3616.

Things To Come

January 4-7

Current Concepts in Pediatrics. Presented by Marion Howard, Ph.D., (Adolescence); Laurie J. Smith, M.D. (Allergy); and James D. Cherry, M.D., Mary P. Glode, M.D., Russell W. Steele, M.D. (Infectious Diseases). Sponsored by the American Academy of Pediatrics. Vail, Colorado. Sixteen Category I credit hours. Fees: AAP Resident Fellow, Candidate Fellow and Allied Health Professionals, $220; AAP Fellow, $300; Nonmember Physician, $365. Further information call 1 (800) 433-9016 and ask for CME Registration.

February 1990

31st Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. Sponsored and presented by the Johns Hopkins University School of Medicine. February - April 1990: Home Study Course A is provided for personal reading and microscopic study in own laboratory in preparation for Course B. April 23 - May 4: In-Residence Course B is an extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore, MD. One hundred and fifty-two Category I credit hours. Registration must be complete before January 1, 1990. For further information contact, John K. Frost, M.D., or Ms. Betty Ann Remley, 111 Pathology Building, Johns Hopkins Hospital, Baltimore, MD 21205; (301) 955-8594.

February 2-3

Advances in Oncology - 1990. Presented and Sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact the Susan Gilson, University of Kentucky, College of Medicine Office Building, Lexington, KY 40536-0086; (606) 233-5161.

February 3-10

1990 Winter Seminar. Presented and sponsored by Baptist Medical Center, Medical Affairs Department. Snowmass, Colorado. Twenty Category I credit hours. Fee: $325, physicians; and $200, nurses, residents and allied health professionals. For further information contact the Medical Affairs Department, Baptist Medical Center, 9601 Interstate 630, Exit 7, Little Rock, Arkansas 72205-7299.

February 16-18

Pediatrics in Progress. Presented by Richard MacKenzie, M.D. (Adolescence); Richard Evans III, M.D. (Allergy; James E. Rasmussen, M.D, (Dermatology); Felix A. Conte, M.D. (Endocrinology); Samuel L. Katz, M.D., (Infectious Disease); and Mel Senac, M.D. (Radiology). Sponsored by the American Academy of Pediatrics. Hyatt Regency Embarcadero, San Francisco, CA. Sixteen Category I credit hours. Fees: AAP Resident Fellow, Candidate Fellow and Allied Health Professionals, $220; AAP Fellow, $300; Nonmember Physician, $365. Further information call 1 (800) 433-9016 and ask for CME Registration.

February 22-25

Eighth Annual Internal Symposium on Man and His Environment in Health and Disease. Presented by an international faculty from England, Belgium, Japan, Canada, China and the United States. Sponsored by The American Environmental Health Foundation and the American Academy of Environmental Medicine. The Grand Kempinski Hotel, Dallas, TX. Twenty-four and one half Category I credit hours. Fees: $345, Physicians; $10/day, Students, resident, interns and Fellows; $295 all other health professionals.

February 22-24

The New Orleans AIDS Conference: Management of HIV Disease for the Primary Care Physician. Presented by Robert Redfield, M.D., Walter Reed Hospital; Michael Hickey, M.D., San Francisco; Michael Polis, M.D., National Institutes of Health; and Ronald Grossman, M.D., New York. Sponsored by the Louisiana State University Medical School and the AIDS Education and Training Center. New Orleans Hyatt Regency Hotel, New Orleans, LA. Fee: $210 before January 25 and $225 after January 25. For further information contact Mr. Bart Reilly, AIDS Education and Training Center, 1541 Tulane Avenue, New Orleans, LA 70112; (504) 568-3855.

February 25 - March 1

Twenty-first Family Medicine Review - Session I. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact the Susan Gilson, University of Kentucky, College of Medicine Office Building, Lexington, KY 40536-0086; (606) 233-5161.

March 4-9

17th Annual Critical Care Medicine Course. Presented and sponsored by the University of Oklahoma Health Sciences Center. Holiday Inn Airport West, Oklahoma City, OK. CME credit available. Fee: $600

includes all workshops, five breakfast buffets and luncheons. For further information, call D. Robert McCaffree, M.D. or Dora Lee Smith at (405) 271-5904 or write: Critical Care Medicine Course, University of Oklahoma Health Sciences Center, Room 3, SP 400, Post Office Box 26901, Oklahoma City, OK 73190.

March 24-29

Spring Meeting of the American Society of Clinical Pathologists. Presented and sponsored by ASCP/CAP. San Francisco Civic Auditorium, San Francisco, CA. CME credit available. For further information, call ASCP at 1 (800) 621-4142.

March 30-31

Contemporary Pediatrics for the Practicing Physicians. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact the Susan Gilson, University of Kentucky, College of Medicine Office Building, Lexington, KY 40536-0086; (606) 233-5161.

March 30 - April 1

Pediatrics 1990. Presented by Elizabeth R. McAnarney, M.D. (Adolescence); Raymond V. Caputo, M.D., (Dermatology); Sarah S. Long, M.D. (Infectious Diseases); Avroy A. Fanaroff, M.D. (Neonatology); Michael J. Goldberg, M.D. (Sports Medicine). Sponsored by the American Academy of Pediatrics. Marco Island Hilton Hotel, Marco Island, FL. Sixteen Category I credit hours. Fees: AAP Resident Fellow, Candidate Fellow and Allied Health Professionals, $220; AAP Fellow, $300; Nonmember Physician, $365. Further information call 1 (800) 433-9016 and ask for CME Registration.

April 5-6

17th Annual Symposium on Obstetrics and Gynecology. Presented and sponsored by the Washington University School of Medicine. Washington University Medical Center, St. Louis, MO. CME credit available. For further information contact, Cathy Caruso, CME, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO; 1 (800) 325-9862.

April 6-7

Aggressive Management of Diabetes and Obesity. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact the Susan Gilson, University of Kentucky, College of Medicine Office Building, Lexington, KY 40536-0086; (606) 233-5161.

Internist - Join cardiologist in university community of 19,000. Close proximity to metro area. 172 bed JCAHO hospital with latest in equipment and large physician referral base. Attractive financial package with excellent coverage available. Office on campus of hospital. Contact Marc McDaniel, Search Consultant, 5000 Linbar Drive, Suite 260, Nashville, TN 37211. 800/678-3616.

EASTERN ARKANSAS - Established OB/GYN in community of 14,000 seeks associate in thriving practice. 120 bed JCAHO hospital with Level II Nursery and excellent medical staff. Office space and attractive financial package available. Contact Jeff Hartline, Search Consultant, 5000 Linbar Drive, Suite 260, Nashville, TN 37211, 800/678-3616.

KEEPING UP

Smoking Cessation

January 12, 12:00 noon. Presented by David Levin, M.D. Sponsored by AHEC Fort Smith. 4th Floor Dining Room, Sparks Regional Medical Center.

1990 Winter Seminar

February 3-10. Presented and sponsored by Baptist Medical Center, Medical Affairs Department. Snowmass, Colorado. Twenty Category I credit hours. Fee: $325, physicians; and $200, nurses, residents and allied health professionals. For further information contact the Medical Affairs Department, Baptist Medical Center, 9601 Interstate 630, Exit 7, Little Rock, Arkansas 72205-7299.

Headaches in Children

February 6, 12:00 noon. Presented by Joseph Bates, M.D. Sponsored by AHEC Fort Smith. Seventh Floor Dining Room, Sparks Regional Medical Center.

Infectious Disease Meeting

February 15, time to be announced. Presented by Robert Bradsher, M.D. Sponsored by UAMS College of Medicine. Little Rock Hilton Hotel. Category I credit and fees to be announced. For further information contact UAMS College of Medicine.

Cardiology Update 1990

February 23, 7:30 a.m. - 4:00 p.m. Presented by Baptist Medical Center Medical Affairs Department. Sponsored by Baptist Medical Center. Baptist Medical Center, J. A. Gilbreath Conference Center. Six Category I credit hours. Fee: $75, physicians; $30, nurses, pharmacists and other allied health professionals.

12th Seminar on Perinatal Medicine

March 1-4, times to be announced. Presented by Frank C. Miller, M.D. Sponsored by UAMS College of Medicine. Orlando, FL. Fees and CME credit to be announced.

Third Annual AIDS Seminar

March 17, times to be announced. Sponsored by the AMS Committee on AIDS. Hot Springs Hilton Hotel, Hot Springs. Program to include general session, concurrent sessions and luncheon speaker. CME credit pending.

25th Annual Surgical Symposium

March 23-24, times to be announced. Presented by Robert Barnes, M.D. Sponsored by UAMS College of Medicine. Hot Springs, AR. Fees and CME credit hours to be announced.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Building Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, Sturgis Building, Room 121
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom

Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Second Floor Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, Sturgis Building, Rooms S120-121
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

AIDS Conference, second Friday, 12:00 noon, La Harpe Room. Sandwich buffet.
CARTI Cancer Conference, first Wednesday, 12:00 noon, CARTI Auditorium. A meal is provided.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. A meal is provided.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Arkla Room. Refreshments are provided.
Internal Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. A meal is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Peripheral Vascular Disease, fourth Tuesday, 6:00 p.m., J. A. Gilbreath Conference Center, Room 8.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES - LITTLE ROCK

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159

Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Rom G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
*Urology Morbidity and Mortality Conferen*ce, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

MEDICINE IN THE NEWS

FDA Recalls L-tryptophan

The Food and Drug Administration said recently it would seek a nationwide recall of all over-the-counter dietary supplements in which L-tryptophan, an amino acid, is the sole or major component of the product because of the rising number of patients taking the product diagnosed as having eosinophilia-myalgia, a rare blood disorder.

Consumers are urged to stop using the L-tryptophan supplements, which are widely available in health food stores as well as such major retail outlets as supermarkets and drug stores.

In November 1989, FDA field officers were asked to identify and mail letters to all manufacturers of the food supplement in their respective jurisdictions asking them to recall these products. Each manufacturer would be expected to contact its clients (wholesalers, distributors, and retailers) to remove the products from the marketplace.

While the investigation continues, the FDA, the Centers for Disease Control and state health officials have now concluded that there is a "strong, virtually unequivocal link between consumption of L-tryptophan tablets or capsules and the syndrome." What has not been established by government scientists is the reason why ingesting L-tryptophan is associated with the syndrome. Most, but not all, of the affected patients have been individuals who were taking L-tryptophan tables, caplets or capsules before becoming ill. The syndrome nearly always involves severe muscle and joint pain, swelling of the arms and legs, skin rash and possible fever. It is characterized by intense eosinophilia, a blood abnormality in which white blood cells increase to abnormally high levels.

Caduceus Club Wins Top Honors

The University of Arkansas for Medical Sciences College of Medicine's Caduceus Club has received top honors in alumni programming from the Association of American Medical Colleges (AAMS) Group on Public Affairs (GPA). The medical alumni organization was recognized in the GPA's Awards for Excellence in Medical Education Public Affairs competition, now in its 19th year.

Janet T. Honeycutt, executive director of the Caduceus Club, accepted a $350 check and a Premier Performance Award in alumni relations from Richard Griffin, GPA chairman-elect and coordinator of this year's competition. The awards were presented at the Association's Annual Meeting, held recently in Washington, D.C.

A panel of three judges selected from past winners of the competition's top award said, "The University of

Arkansas and its Caduceus Club are fortunate to have a person of Ms. Honeycutt's tenacity and ingenuity."

The contest attracted national entries from medical schools, teaching hospitals and academic medical centers.

FDA Approves Continuous IV Infusion of Tagamet®

The U.S. Food and Drug Administration has approved the use of Tagamet®(brand of cimetidine) administered as a continuous intravenous infusion, SmithKline Beecham has announced. It is the only drug in its class to receive approval for dosing by continuous infusion.

Continuous IV infusion of Tagamet controls pH continuously for 24 hours, avoiding peaks and troughs in serum drug concentrations, and provides appreciable cost savings to healthcare providers in the hospital pharmacy and the bedside. The cost savings result primarily from decreased pharmacy and nursing staff time for drug administration.

The continuous infusion dosage regimen for the ulcer patient requiring IV therapy is 900 mg/day (37.5 mg/hr). If a more rapid onset of action is desired, a loading dose of 150 mg or 300 mg can be used. The full prescribing information should be read carefully before administering Tagamet by continuous infusion or any other route.

New Members

CONWAY COUNTY

Petit, Carl A., General Surgery, Morrilton. Born December 6, 1933, Lima, Peru. Medical education, Cordoba University, Cordoba, Argentina, 1960. Internship, Cordoba University Medical School. Residency, New York Hospital, N.Y Good Samaritan Hospital, Portland, Oregon. Practice experience, 16 years, Kansas City, MO; Kansas City, KS; and Overland Park, KS. Board certified. Member, Internal College of Surgeons, Royal College of Surgeons of Canada, American Society of Abdominal Surgeons; Southwestern Surgical Congress, Kansas City Surgical Society; and International Academy of Proctology.

DALLAS COUNTY

Moran, Paul A., Family and General Practice, Fordyce. Born January 13, 1941, Tulsa, OK. Pre-medical education, Northeastern State University. Medical education, University of Health Sciences, Kansas City, MO, 1968. Internship/residency, East Town Hospital Metropolitan. Practice experience, Wichita, KS; Tyler, TX; Aspermont, TX.

PULASKI COUNTY

Baker, Yvette K., Neurology. Little Rock. Born December 19, 1958, Los Angeles, CA. Pre-medical education, University of Arkansas, Fayetteville, B.S., 1981. Medical education, University of Arkansas for Medical Sciences, 1985. Internship/residency, UAMS. Board eligible.

Cook, L. Scott, Cardiothoracic Surgery, Little Rock. Born December 6, 1948, Searcy, AR. Pre-medical education, University of Tennessee, Memphis, Ph.D., 1978. Medical education, University of Arkansas for Medical Sciences, 1981. Internship/residency, University of Oklahoma, Oklahoma City; University of Kansas, Kansas City. Teaching experience, Assistant Professor, Surgery, UAMS. Board certified, Surgery.

SEBASTIAN COUNTY

Martimbeau, Claude L., Orthopaedics, Fort Smith. Born March 3, 1944, Montreal, Canada. Premedical education, College of Montreal, 1965. Medical education, University of Montreal, 1969. Internship. Notre Dame Hospital, Montreal. Residency, University of Montreal. Fellowship, Paris, trauma - pelvis and hand, 1976. Practice experience, 6 years, Montreal; 4 years, University of Loma Linda, CA; 2 years, Fort Smith. Teaching appointments, Assistant Professor, University of Montreal; Loma Linda University. Board certified, Orthopaedics. Member, Fellow, AAOS.

RESIDENT SECTION

Chai, Sandra E., Internal Medicine. Born June 7, 1962, Wayburn, Saskatchewan, Canada. Pre-medical education, University of Oklahoma, B.S. Medical education, University of Oklahoma College of Medicine, 1988.

Morris, Barbara, Otolaryngology. Born May 4, 1952. Medical education, UAMS, 1986.

Petersen, Pamela O., Pediatrics. Born October 29, 1961, Des Moines, IA. Pre-medical education, Iowa State University, B.S., 1984. Medical education, University of Iowa, 1988. Internship/residency, UAMS.

Arkansas Medical Society Roster of Membership as of December 11, 1989

- Deceased

Arkansas

Burleson, Stan W.
Daniel, Noble B. III
Guyer, G. L.
Hestir, John M.
John, Milton C. Jr.
Millar, Paul H. Jr.
Morgan, Jerry D.
Northcutt, Carl E.
Pritchard, Jack L.
Speer, Hoy B. Jr.
Speer, Marolyn N.
Wilson, Richard
Wood, Gary P.
Yelvington, Dennis B.

Ashley

Birriel-Salcedo, Tomas
Burt, Frederick N.
Cothern, William R. #
Garcia, Luis F.
Gresham, Edward A.
Holt, Terry
McLean, Joseph A.
Rankin, James D.
Ripley, Curtis E.
Salb, Robert L.
Thompson, Barry V.
Toon, D. L.
Walsh, Benjamin J.

Baxter

Baker, Robert
Beard, Arthur L.
Chatman, Ira D.
Cheney, Maxwell G.
Chock, Daniel P.
Chock, Helga E.
Clarke, James S.
Condrey, Yoland M.
Cook, James T.
Douglas, Donald S.
Dunbar, James C.
Dykstra, Peter C.
Fontenot, Edwin Jr.
Guenthner, John F.
Haller, Nancy Timmons
Hardin, Philip R.
Johnson, Stacey M.
Kelley, Lawrence A.
Kerr, Robert L.
Knox, Thomas E.
Landrum, William
MacKercher, Peter A.
Marx, Douglas
Massey, James Y.
McGaughey, Allen S.
Rigler, Wilson F.
Roberts, David H.
Sneed, John W. Jr.
TerKeurst, John
Trager, Marc H.
Tullis, Joe M.
Turner, Frederick C.
Wells, Gary
Wilbur, Paul F.
Wilson, Jack C.

Benton

Adams, Frank
Addington, Alfred R.
Adrian, James A.
Allen, L. Barry
Allen, William M.
Arkins, James
Atkinson, Thomas
Ball, Eugene H.
Becton, Paul Jr.
Benjamin, George
Bledsoe, James H.
Boozman, Fay W. III
Carter, Vernon H. #
Claytor, Tonya C.
Clemens, R. Dale
Clower, John D.
Cohagan, Donald L.
Cole, Randall E.
Compton, Neil E.
Costaldi, Mario E.
Dang, Minh-Tam
Diacon, W. Lindley
Donnell, Robert W.
Drange, R. Kirk
Elkins, James P.
Fioravanti, Bernard L.
Garrett, David C. III
Goss, Stephen
Hackler, Keith
Harmon, Harry M.
Hearnsberger, H. Graves III
Henderson, Oscar L.
Hitt, Jerry L.
Hof, C. William
Hoffman, Carl E.
Holder, Robert E.
Horner, Glennon A.
Howard, K. Lamar
Howard, Willard H. Jr.
Hull, Robert R.
Huskins, James D.
Huskins, John A.
Jacks, John W.
Jennings, William E.
Kendrick, Carl M.
Knapp, James R.
Martin, Albert Jr.
McCollum, Edward N.
McKnight, William D.
Miles, Richard W.
Moffitt, Gary
Moose, John I.
Mullins, Neil D.
Neaville, Gary A.
Panettiere, Frank J.
Pappas, John J.
Pearson, Richard N.
Pickens, James L.
Platt, Michael R.
Puckett, Billy J.
Reese, Michael C.
Ritz, Ralph C.
Robbins, Robert H.
Rollow, John A.
Rolniak, Wallace A.
Steadman, Hunter M. Jr.
Stinnet, Scott G.
Stinnett, Charles H.
Stolzy, Sandra
Stone, W. Tex #
Summerlin, William
Swaim, Terry J.
Swindell, William G.
Treptow, Douglas
Turley, Jan T.
Waldon, Gene B.
Warren, Grier D.
Weaver, Donald D.
Weaver, Robert H.
Webb, William
Wright, Larry D.
Youngblood, Thomas

Boone

Ashford, Walter P.
Bell, Thomas Edward
Bennett, Chris
Bennett, Joe D.
Carter, J. Brad
Chambers, Carlton L. III
Daniel, Charles D.
Dunaway, Geoffrey
Ferguson, Noel F.
Fowler, Ross E.
Garland, William J. Jr.
Gladden, Jean C.
Hoberock, Thomas R.
Hudson, William A.
Kirby, Henry V.
Klepper, Charles R.
Kuharich, Richard M.
Langston, Robert H.
Laule, Alice R.
Ledbetter, Charles A.
Leslie, Thomas S.
Mahoney, Paul L. Jr.
Miller, Robert Jr.
Rozeboom, Victor A.
Scroggins, Sam J.
Simpson, Thomas J.
Smith, H. Van
Troupe, John T.
Vowell, Don R.
Williams, Rhys A.

Bradley

Chambers, F. David
Marsh, James W.
Pennington, Kerry F.
Schultz, Wayne H.
Wharton, Joe H.
Wynne, George F.

Carroll

Card, Shannon R.
Finfrock, William
Flake, William K.
Green, Jess D. Jr.
Kresse, Gregory
Spurgin, Randal Truman
Stensby, Harold F.
Taylor, Richard L.
Wallace, Oliver

Chicot

Berry, Danny T.
Burge, John P.
DeRamos, Agapito Y.
Heder, Guy W.
Knuiper, Gregory
Russell, John R.
Smith, Major E.
Thomas, H. W.
Tuangsithtanon, T.
Tvedten, Tom
Vogel, Wrede E.
Weaver, William J.
Wilson, Thomas C.

Clark

Anderson, P. R.
Balay, John W.
Hagood, Noland Jr.
Kennedy, Jack #
Lowry, James
Parsons, V. Earl Jr.
Peeples, George R.
Studdard, Daniel
Taylor, George D.
Toombs, Vernon L.

Cleburne

Baldridge, Max
Barnett, James C.
Barnett, Michael
Beasley, Harold
Campos, Amador
Eans, Thomas L.

Ewing, Jon R.
Poff, Joseph H.
Poff, Nathan L.

Columbia

Alexander, John E. Sr.
Alexander, John E. Jr.
Antoon, Patrick D.
Baldwin, Ronald L.
Evans, Matthew L.
Farmer, John M.
Griffin, Rodney L.
Hunter, Robert W. Jr.
Kelley, Charles W.
McMahen, H. Scott
Murphy, Fred Y.
Pullig, Thomas A.
Roberts, Franklin D.
Ruff, John L.
Strange, Vance M.
Walker, Jack T.
Weber, Charles

Conway

Hickey, Thomas H.
Lipsmeyer, Keith M.
Owens, Gastor B.
Rozzell, Allen R.
Wells, Charles F.

Craighead-Poinsett

Alston, Herman D.
Anderson, Charles
Aston, J. Kenneth
Atkinson, Robert
Austin, Lester K. Jr.
Ball, John
Barker, Charles
Basinger, James W.
Berry, Donald M.
Blachly, Ronald J.
Blanchard, Steven
Blaylock, Jerry D.
Bodeker, Larry J.
Bradley, James F. Jr.
Brown, Mark C.
Buckner, John H.
Burns, Richard G.
Carpenter, Kennan
Clopton, Owen H. Jr.
Cohen, Robert S.
Cook, John
Crawley, Michael E.
Dickson, Glenn E.
Duplantis, Kathryn
Eddington, William R.
Emerson, Steven
Felts, Larry S.
Forestiere, A. J.
Frey, Robert D.
Garner, William L.
George, F. Joseph
Golden, Stephen C.
Gossett, Clarence E.
Goza, Gary R.
Green, Wm. Robert
Guinn, Donald R.
Hall, Ray H. Jr.
Herman, Ellen
Hiers, Connie L.
Hightower, Michael D.
Hill, Roger D.
Hogue, Ernest L.
Hubbard, William S.
Isaacson, Michael L.
James, Frank M.
Jennings, R. Duke
Jiu, John B.
Johnson, Larry H.
Johnson, Roehl W.
Jones, K. Bruce
Jones, R. J.
Jordan, Harry J.
Keisker, Henry W.
Kemp, Charles E.
Kroe, Donald J.
Lassonde, Robert G.
Lawrence, Robert O. Jr.
Ledbetter, Joseph W.
Lepore, Diane G.
Levinson, Mark
Lunde, Stephen P.
Lyons, Lewis C.
Mackey, Michael
Maglothin, Douglas L.
Mahon, Larry E.
McDaniel, Craig A.
McKee, Bobby E. #
Mitchell, George E.
Modelevsky, Aaron C.
Montgomery, Earl W.
Moore, Steven M.
Nash, Jerry
Nixon, D. Allen Jr.
Owens, Ben Jr.
Peeler, Malcolm O.
Porter, Revel D.
Price, Edwin F.
Price, Herbert H. III
Pyle, David
Rainwater, W. T.
Raney, Bascom P.
Robbins, Robert A.
Roberts, Randy D.
Robinette, James M.
Rogers, James F.
Rusher, Albert H. Jr.
Ryals, Rickey O.
Sanders, James W.
Sapiro, Gary S.
Saunders, Earnest
Savage, Patrick Joseph
Schrantz, James L.
Schweitzer, Terri
Scriber, Ladd J.
Shanlever, Rufus C.
Shanlever, William T.
Silas, David
Skaug, Phyllis
Skaug, Warren A.
Smith, Floyd A. Jr.
Smith, Vestal B.
Souther, Susan
Sparks, Barrett
St. Clair, John T. Jr.
Stainton, Joseph C.
Stainton, Robert M. Jr.
Stallings, Joe H. Jr.
Stevenson, Richard
Stewart, Mark
Stripling, Mark C.
Swingle, Charles G.
Taylor, Robert D.
Tedder, Michael E.
Teply, Joseph F.
Thomas, J. Fred
Tonymon, Kenneth
Tullis, Gene
Utley, Phillip M.
Verser, Joe
Vines, Troy Alan
Vollman, Don B. Jr.
Webb, James W.
White, Anthony T.
Wiggins, H. Lynn
Williams, E. Walden
Wilson, Joe T. Jr.
Wisdom, Garland Durwood
Woloszyn, John
Woodruff, Stephen O.
Yates, Robert L.
Young, S. Morris
Young, William C. Jr.

Crawford

Darden, Lester R.
Edds, Millard C.
Edwards, Henry N.
Gilmore, Owen B.
Harford, Martin
Hefner, David P.
Jennings, Charles A.
Ross, R. Wendell
Sasser, L. Gordon III
Shearer, Francis E.
Sills, D. Bart
Travis, A. Lawrence

Crittenden

Adler, Justin Jr.
Arnold, Sidney W.
Bryant, Glen E.
Deneke, Milton D.
Evans, Loraine J.
Ferguson, Edgar
Ferguson, T. Murray
Ford, Robert C. Jr.
Hamilton, Ralph B.
Hernandez, Jacinto
Herrington, C. G. Cap Jr.
Huffstutter, Paul J.
Jay, Gilbert D. III
Kennedy, Keith B.
L'Heureux, Guy J.
Lubin, Milton
Meredith, Samuel G. Jr.
Miller, James L.
Nadeau, Kenneth R.
Peeples, Chester W. Jr.
Pierce, Trent P.
Schoettle, Glenn P.
Schoettle, Steve P.
Shrader, Floyd R.
Smith, Bedford W.
Smith, Mark M.
Utley, L. Thomas
Wah, John
Webb, Dan W.
Westbrook, H. Wade
Wright, William J.

Cross

Beaton, James
Beaton, Kenneth E.
Bethell, Robert D.
Burks, Willard G.
Crain, Vance J.
Hayes, Robert A. Jr.
Jacobs, James R.
Young, John H.

Dallas

Davis, Paul
Delamore, John H.
Dobson, Jack T.
Howard, Don
Nutt, Hugh A.

Desha

Go, Peter Kong Hua
Harris, Howard R.
Hoagland, Robert A.
Robinson, Guy U.
Turney, Lonnie R.

Drew

Binns, Van C.
Burns, Robert E.
Busby, Arlee K.
Maxwell, Ralph M.
McKiever, William R.
Oxner, Troy Wayne
Wallick, Paul A.
Wilson, Harold F.

Faulkner

Archer, Charles A. Jr.
Banister, Bob G. #
Benafield, Robert B.
Connaughton, Michael A.
Daniel, Sam V.
Furlow, William C.
Garrison, James S.
Gordy, L. Fred Jr.
Hendrickson, Richard O. Jr.
Horton, Charles
Jackson, Carole Bryant
Magie, Jimmie J.
McChristian, Paul L.
Murphy, Kenneth
Shirley, David C.
Smith, John D.
Smith, Lander A.
Stancil, Vicki
Stone, Phillip
Throneberry, Bart

Franklin

Gibbons, David L.
Long, C. C.
Smith, John C.

Garland

Arthur, James M.
Aspell, Robert
Atherton, Lee G.
Atkinson, Robert H.
Bandy, Preston R.
Beamer, Lee F.
Bodemann, Michael C.
Bodemann, Stephen L.
Bohnen, Loren O.
Borg, Robert V.

Bracken, Ronald J.
Braley, Richard E.
Braun, James R.
Brunner, John H.
Bumpas, Timothy F.
Burton, Frank M.
Burton, James F.
Campbell, James W.
Cates, Jack A.
Chamberlain, Joe W.
Cofer, Thomas
Crabtree, John H.
Cupp, Cecil W. III
Davis, Sheryl L.
Dembinski, T. Henry
Dodson, John W. Jr.
Dunn, Richard W.
Durham, Thomas M. Jr.
Edwards, Gwilym A. #
Eisele, W. Martin
English, P. Timothy
Finan, E. Michael
Fore, Robert W.
Fotioo, George J.
French, James H.
Gardial, J. Richard
Gardner, James L.
Garner, Onyx P.
Griffin, James E.
Haggard, John L.
Harper, Edwin L.
Harsh, Karen L.
Hechanova, D. M. Jr.
Heinemann, Fred M.
Hill, Robert L.
Hollis, Thomas H.
Howe, H. Joe
Humphreys, Robert P.
Irwin, William G.
Jackson, Haynes G.
Jayaraman, K. K.
Jayaraman, Vilasini D.
Jayasundera, Naomal S.
Johnson, Paulette S.
Johnson, Robert D.
Johnston, Gaither C.
Kaler, Ron A.
Keadle, William R.
Kincheloe, A. Dale
King, Leeman H.
Kleinhenz, Robert W.
Klugh, Walter G. Jr.
Koehn, Martin A.
Krishnan, Bhaktan
Lang, Patricia A.
Larrison, Charles A.
Lee, William R.
Lewis, Robert L.
Lovell, Clawrence R.
Madsen, Henrik II
Maruthur, Gopakumar
Mashburn, William R.
McConkie, Stuart B.
McCrary, Robert F. Jr.
McFarland, Louis R.
McMahan, James C.
Meek, Gary N.
Munos, Louis R.
Newton, Doane M.
Pai, Balakrishna V.
Pappas, Deno P.
Parkerson, Cecil W.
Peeples, Raymond E.
Powell, Brenda
Queen, George P.
Rainwater, W. Sloan
Reddy, Prabhakara K.
Robert, Jon M.
Robertson, Fred T.
Rosenzweig, Joseph L.
Sanders, Hallman E.
Schmidt, Clinton C.
Seifert, Kenneth A.
Shelby, Eugene M.
Shroff, Rajesh K.
Simpson, John B.
Slaton, Catherine R.
Slaton, G. Don
Slezak, James
Smith, Bruce L. Jr.
Smith, John
Smith, Phillip L.
Sorrels, John W.
Springer, Melvin R. Jr.
Springer, William Y.
Stecker, Elton H. Jr.
Stecker, Rheeta M.
Stough, Dowling Bluford III
Thomas, W. Al
Thompson, Thomas P. Jr.
Trieschmann, John W.
Tucker, R. Paul
Wade, H. King Jr.
Wallace, Thomas R.
Walley, Luther R.
Webb, Timothy
Woodward, Philip A.
Wright, Charles C.
Wright, William J.
Wyatt, Richard A.

Grant

Irvin, Jack M.
Paulk, Clyde D.

Greene-Clay

Baker, A. J.
Baker, Clark M.
Boggs, Dwight F.
Bonner, J. Darrell
Cagle, Roger E.
Collier, George H. Jr.
Crow, Asa A.
Duckworth, Hillard R.
Futrell, Junius B.
Hardcastle, R. Lowell
Harper, Bland R.
Hazzard, Marion P.
Hobby, George A.
Jones, Bryant W. #
Kemp, Clarence
Lawson, J. Larry
Martin, Richard O.
Mitchell, Bennie E.
Muse, Jerry L.
Page, Billie C.
Purcell, Donald I.
Richmond, Jack G.
Sellars, John R.
Shedd, Leonus L.
Sheridan, James G.
Shotts, C. Mack Jr.
Shotts, Vern Ann
Watson, Samuel D.
White, Robert B.
Williams, Dwight M.
Williams, Jacob M.

Hempstead

Branch, James W. Sr.
Dodd, N. Leland
Harris, Lowell O.
Holt, Forney G.
Martindale, James G.
McKenzie, Jim
Portis, Richard P.
Stevens, David G.
Wright, George H.

Hot Spring

Bollen, A. Ray
Brashears, Larry B.
Burton, Bruce K.
Cobb, Russell W.
Dunn, Robert
Ellis, C. Randolph
Highsmith, Vivian F.
Kersh, N. B.
Loyd, Gregory M.
Peters, Claude F.
Vaughan, John A.
White, Bruce A.
White, Robert H.

Howard-Pike

Floyd, Mark A.
Gullett, A. Dale
Hearnsberger, John E.
Humphreys, T. J. Jr.
King, Joe D.
Peebles, Samuel W.
Pye Ted H. #
Sykes, Robert
Turbeville, James O.
Ward, Hiram T.
White, Phillip L.

Independence

Akin, Charles R.
Allen, James D.
Baker, John R.
Baker, Robert V.
Baxley, Paul J.
Beck, Carl T.
Bess, Lloyd G.
Brown, Verona T.
Davidson, Dennis O.
Fulbright, Thomas
Goodin, William H. Jr.
Hays, Sarah F.
Jones, Edward J.
Jones, Edward T.
Ketz, Wesley J.
Lambert, John S.
Luter, Dennis W.
Lytle, Jim E.
McClain, Charles M. Jr.
Moody, Lackey G.
O'Brien, Marcus D.
Raney, W. Troy
Scott, John G.
Simpson, Ronald
Slaughter, Bob L.
Sloan, Fredric J.
Smith, Bob G.
Stalker, James M.
Strickland, Nathan E.
Sutterfield, Terry F.
Taylor, Chaney W.
Taylor, Charles A.
Tucker, Charles L.
Waldrip, William J. III
Walton, Robert B.
Zini, James E.

Jackson

Ashley, John D. Jr.
Carney, J. W.
Chauhan, Mufiz A.
Dudley, Guilford M. III
Foote, John W.
Frankum, Jerry M. Jr.
Green, Roger L.
Hergenroeder, Paul J.
Jackson, Jabez Fenton Jr.
Junkin, A. Bruce
Lopez, Ramon E.
Poon, Hon K.
Reynolds, Roland C.
Williams, Thomas E.
Young, Jack S. III

Jefferson

Anderson, Charles W.
Anderson, Daphne
Anderson, Mark
Armstrong, Simmie Jr.
Atkinson, Evangelina
Atkinson, Robbie
Atnip, Gwyn
Attwood, H.
Bell, Carl H. Jr.
Bennett, Keith
Blackwell, Banks
Bracy, Calvin M.
Brooks, R. Teryl Jr.
Buckley, J. Wayne
Burford, Thomas G.
Busby, John
Butler, Robert C.
Campbell, James C. Jr.
Carlton, Irvin L.
Cheek, Ben H.
Clark, James F. Jr.
Coker, L. Randle
Crenshaw, John
Davis, Charles M.
Dedman, John D.
Deneke, William
Duckworth, Thomas S.
Estes, David
Fendley, Claude E.
Fendley, Herbert F.
Flowers, Martha A.
Forestiere, Lee A.
Freeman, William H.
Frigon, Gary F.
Frigon, Jacquelyn S.
Fuller, C. James III
Glasscock, Robert E.
Green, Horace L.
Gullett, Robert R. Jr.
Hardin, J. David

Harper, William F.
Hegwood, H. Melvin
Henderson, Francis M.
Hughes, L. Milton
Hussain, Shafqat
Hutchison, E. L.
Hyman, Carl A.
Hyman, Carl E.
Irwin, Raymond A. Jr.
Jacks, David C.
Jacks, Dennis
James, William J.
Jenkins, Bobby
Jenkins, Mary Ellen
Joseph, Aubrey S.
Justiss, Richard D.
Khan, Mahmood A.
King, Yum Y.
Langston, Lloyd G.
Ligon, Ralph E.
Lim, William N.
Lindsey, James A.
Lum, Don
Lupo, David A.
Lytle, John O.
Mabry, Charles D.
Martin, Kenneth A.
Maynard, Ross E.
McDonald, Robert L.
McGee, Mary
Mehta, Shyam P.
Meredith, William R.
Miller, Donald L.
Milligan, Monte C.
Monroe, Sanford C. #
Morris, Harold J.
Nichols, William
Nixon, David T.
Nixon, William R.
Nuckolls, J. William
Pashkevick, Michele A.
Pearce, Malcolm B.
Perry, V. Bryan
Pierce, J. R. Jr.
Pierce, Ruston Y.
Rainey, William C.
Raney, Oliver C.
Reid, Lloyene B.
Ridling, Anna T.
Rittelmeyer, Clarence M.
Roaf, Sterling A.
Roberson, George V. Jr.
Robinette, Joseph S.
Rogers, Henry L.
Ross, Robert L.
Samuel, Ferdinand K.
Shorts, Stephen D.
Simmons, Calvin R.
Simpson, P. B. Jr.
Smith, Paul L.
Sparrow, Martha
Stem, Howard S.
Stillenberger, A. G.
Sweatt, John
Tanner, Ronald D.
Tisdale, Alfred D. Jr.
Toatley, Donald U.
Townsend, Thomas E.
Tracy, C. Clyde
Waheed, Atiya N.
Walajahi, Fawad H.
Washington, Erma
Watson, Charles
Watson, Vye B.
Wilkins, Walter J. Jr.
Wineland, Herbert L.
Worrell, Aubrey M. Jr.

Johnson

Boswell, Clifford A.
Goodman, James David
McAuley, John R.
McKelvey, Richard E.
Patterson, Jack T.
Pennington, Donald H.
Shrigley, Guy P.

Lafayette

Lee, Willie J.
Patton, Robert C.

Lawrence

Hughes, Joe E.
Joseph, Ralph F.
Lancaster, Ted S.
Langley, Michael G.
Quevillon, Robert D.
Spades, Sebastian A. III

Lee

Balke, Susan W.
Fields, E. C.
Gray, Dwight W.
Ly, Duong N.

Little River

Armstrong, James
Dalby, Robert D.
Peacock, Norman W. Jr.
Shelton, Joe G. Jr.
Wade, Billy K.

Logan

Buckley, Douglas A.
Chalfant, Charles
Daniel, William R.
Enns, Wayne P.
Harbison, James D.
Hutson, Sanford E. III
Roberts, William J.
Smith, James T.
Ulrich, Guy
Williams, John R.

Lonoke

Abrams, Joe A.
Anderson, Leslie
Booe, Leroy Jr.
Braswell, Thomas
Chapman, Jerry C.
Davidson, Andy
Elam, Garrett
Gartman, Joseph F.
Holmes, Byron E.
Inman, Fred C. Jr.
Schumann, Gerald M.
Washburn, C. Yulan

Miller

Andrews, A. E. Jr.
Barnes, Walter C. Jr.
Blankenship, D. Michael
Brown, Sam F.
Burns, Billy R.
Burroughs, James C.
Chipman, Dennis C.
Cummins, J. Craig
Cutler, Otis
Deskin, Roy L.
Dildy, Edwin V. Jr.
Ditsch, Craig E.
Dodge, John M.
Druff, Gerald H.
Duncan, Donald L.
Eichler, Edward A. Jr.
Ford, John Suffern
Fournier, Donald C.
Gabbie, Mark
Gillean, John A.
Graham, John
Hall, Eric E.
Hall, Jon D.
Harrell, William B. Jr.
Harris, C. Lynn
Harrison, Jack W.
Hillis, Thomas M.
Hughes, A. Keith
Hughes, R. Paul
Hurley, James M.
Hutcheson, Fred A. Jr.
Jean, Alan B.
Jones, John W.
Joyce, Frederick E.
Kemp, Karlton H.
Kittrell, James B.
Knowles, Stanley C.
Leavelle, Ray W.
Lee, Allen R.
Loe, Arlis W.
Mayo, Russell
McGinnis, Robert S. Sr.
Meredith, Paul D.
Morris, Howard
Newton, Norris L.
Newton, Norris L. Jr.
Norris, John A.
O'Banion, Dennis
Peebles, Larry M.
Ridout, Robert M. Jr.
Robbins, Joseph
Rountree, Glen A.
Royal, Jack L.
Sarrett, James
Shaffer, William L.
Shipp, G. Carl
Smith, Arnett D. Jr.
Solomon, J. Alan
Somerville, Patrick J.
Stringfellow, Jerry B.
Thornton, Charles N.
Tompkins, W. C. Jr.
Vereen, Lowell E.
Warren, William Jr.
Wilhelm, Frieda
Wren, Herbert B.
Wright, James O. III
Yarbrough, Charles P.
Young, Mitchell

Mississippi

Abraham, Anes Wiley
Abramson, Lawrence
Bell, Mary C.
Biggerstaff, Jerry R.
Brock, Charles C. Jr.
Campbell, Charles E. Jr.
Cole, Cecil R.
Cullom, Sumner R.
Fairley, Eldon
Fergus, R. Scott
Hall, Leslie
Haynes, Max G.
Hester, Karen
Hester, Richard
Higley, George B. Jr.
Hubener, Louis F.
Hudson, James H.
Husted, G. Scott
Johnson, Jonathan H.
Jones, Herbert
Jones, Joseph V.
Melton, Clinton G.
Osborne, Merrill J.
Oster, Catherine J.
Pollock, George D.
Rauls, Stephen R.
Rhodes, Joseph
Rhodes, R. F.
Rodman, T. N.
Russell, James D.
Sammons, L. C. Jr.
Sellers, Kenneth D.
Shaneyfelt, E. A.
Sims, Hunter C. Jr.
Smith, Ronald D.

Monroe

David, Neylon C. Jr.
Pham, Dac Tat
Pupsta, Benedict F.
Stone, Herd E. Jr.
Walker, Walter L.

Nevada

Crow, H. Blake
Vermont, Charles

Ouachita

Braden, Lawrence F.
Brunson, Milton
Crump, Mark
Dedman, J. L. Jr.
Dedman, William D.
Fohn, Charles H.
Forward, Robert B.
Guthrie, James
Hout, Judson N.
Jameson, John B. Jr.
Kendall, Jerry R.
McFarland, Gale
Miller, John H.
Nunnally, Robert H.
Ozment, L. V.
Parkman, Robert L. Jr.
Sanders, Cal R.
Thorne, Arthur E.

Phillips

Barrow, John H. Jr.
Bell, L. J. Patrick
Berger, Alfred A.

Duensing, Theodore
Elovitz, Maurice J.
Faulkner, Henry N.
Frederick, William Ronald
Greening, Billy
Kirkman, C. M. T.
McCarty, Charles P.
McCarty, Gordon E. Jr.
McDaniel, Marion A.
Miller, Robert D. Jr.
Paine, William T.
Patton, Francis M.
Rangaswami, Narayanaswami
Robirds, David Mark
Vasudevan, Kanaka
Vasudevan, P.
Wise, James E. Jr.

Polk

Finck, John Henry
Fried, David D.
McClard, P. Helen
Mesko, John D.
Rogers, Henry N.
Tinnesz, Thomas
Wood, John P.

Pope

Ashcraft, Ted
Austin, Nathan
Bachman, David S.
Barron, William G.
Barton, A. Dale
Battles, Larry D.
Beavers, Kevin
Berner, Dennis W.
Birum, Patricia J.
Bost, R. Kingsley
Bradley, Stanley C.
Brown, Charles H.
Burgess, James G.
Callaway, Jody C.
Carter, James M.
Cloud, Joe A.
Crumpler, Joe B. Jr.
Dunn, Donald L.
Ferris, Craig
Galloway, William W.
Harrison, Rick
Hendren, Mike
Henry, J. Arnold
Hill, Donald F.
Hollabaugh, Denise
Honghiran, Ted
Kerin, Douglas
Killingsworth, Stephen M.
King, John W.
King, W. Ernest Jr.
Kolb, James M. Jr.
Lahr, Charles H.
Lane, Walter H. Jr.
Lawrence, Frank M.
Lovell, Richard K. Sr.
Lowrey, Douglas H.
Lyford, Joe H. Jr.
Malone, George E.
Mauch, E. Jane
May, Robert H. Jr.
Meyer, Kelly H.
Mobley, Max J.
Monfee, Andrew M.
Myers, J. Mark
New, Kenneth O.
Patterson, William D.
Riddell, C. Michael
Riley, Don C.
Speed, Darrell
Stolz, Gerald A. Jr.
Teeter, Stanley D.
Thurlby, W. Robert
Turner, Finley P. II
Wilkins, Charles F. Jr.
Williams, David M.
Young, Sandra S.

Pulaski

Abbott, William W.
Abel, Lee C.
Abraham, James H.
Abraham, Robert E.
Adametz, James
Adametz, John
Adamson, James
Alford, T. Dale
Allen, Durward Jr.
Allen, E. Stewert
Allen, John E. Jr.
Allen, Thomas
Alston, Phillip
Amir, Jacob
Aquino, Al
Araoz, Carlos
Armstrong, Howard
Arrington, Robert
Ashcraft, Keith
Ault, Charles C.
Austin, R. Lee
Autry, Daniel H.
Baber, John C. Jr.
Baber, John T.
Backus, Joe T.
Bailey, H. A. Jr.
Baker, Glen F.
Baker, Johnson
Baker, Susan W.
Baker, Yvette
Baldwin, Maxwell R.
Ballard, Clarence E. Jr.
Barber, Jeffrey
Barclay, David
Bard, David S.
Barger, Denver L.
Barlow, Brian E.
Barnes, Robert W.
Barnett, David
Barnett, Troy F.
Barron, Edwin N. Jr.
Bates, Ramona
Bates, Stephen
Batres, Francisco
Bauer, F. Michael
Bauer, Frank M. Jr.
Bauman, David C.
Beadle, Beverly
Bearden, James R.
Beaton, J. Neal
Beck, Joseph II.
Becquet, Norbert J.
Belknap, Melvin L.
Bennett, Eaton W.
Bennett, F. Anthony Jr.
Berry, Frederick B.
Berry, Robert L.
Bevans, David W. Jr.
Bienvenu, Gregory
Biondo, Raymond V.
Birkett, Ian McRae
Bishop, William B.
Black, H. Thurston
Black, Hal R. Jr.
Blackshear, Jack L. Jr.
Blankenship, William F.
Boellner, Samuel W.
Boger, James E.
Boop, Warren C. Jr.
Bornhofen, John H.
Bost, Roger B.
Bowen, William
Bowles, Mark
Box, Jim F.
Boyd, Charles M.
Boyle, Ronald H.
Bozeman, Barbara J.
Bradburn, Curry B. Jr.
Bradley, Joe F.
Brainard, Jay O.
Brenner, George H. Jr.
Bressinck, Renie E.
Brewer, Robert M.
Brimberry, Ronald K.
Brinkley, Roy A.
Brizzolara, A. J.
Brizzolara, John Paul
Broach, R. Fred
Brown, Michael F.
Brown, Pamela
Brown, Scott H.
Browning, Donald G.
Browning, Stanley K.
Brunson, Ashley
Bryant, Deborah M.
Buchanan, Francis R.
Buchanan, Gilbert A.
Buchman, Joseph A.
Buchman, Joseph K.
Bucolo, Anthony P.
Budhraja, Madhu S.
Budhraja, Meenakshi
Buford, Joe L.
Bumpas, Joe H.
Burger, Robert A.
Burnett, Hugh F.
Burnham, William W.
Burrow, Dennis R.
Byrd, Lucas M. Jr.
Byrum, Jerry
Cain, Thomas
Calcote, Robert A.
Calhoon, J. Dale
Calhoun, Joseph D.
Calhoun, Richard A.
Campbell, Gilbert S.
Campbell, James W.
Caplinger, Kelsy J. III
Carfagno, Jeffrey
Carnahan, Robert G.
Carson, Layne E.
Carter, Jerry L.
Caruthers, Samuel B. Jr.
Casali, Robert E.
Casper, Robert B.
Cathey, Janet
Cathey, Steven
Chakales, Harold H.
Chandler, Billy M.
Chappell, Carol W.
Cheairs, David B.
Cheairs, John T.
Chesser, Michael Z.
Chisholm, Dan P.
Choate, Robert B.
Christeson, William W.
Christian, John D.
Chudy, Amail
Church, Beresford L.
Church, Marion M.
Church, Michael
Clark, Richard B.
Clift, Steven A.
Clifton, Cliff
Cobb, Jock S.
Cockrill, H. Howard Jr.
Cogburn, Bob E.
Colclasure, Joe B.
Cone, John
Cook, L. Scott
Cook, Raymond C. #
Cornell, Paul J.
Cosgrove, Kingsley W. Jr.
Craig, Marion S. Jr.
Crews, J. Travis
Crocker, Charles H.
Cross, J. B.
Crow, Joe W.
Crow, R. Lewis Jr.
Curtner, Bryon D.
Dalrymple, Glenn V.
Daugherty, Joe D.
Daugherty, John L.
Davie, Melanie
Davis, Glenn R.
Davis, J. Lynn
DeLoach, John Jr.
Dean, David M.
Dean, Gilbert O.
Deaton, Charles Jr.
Deer, Philip J. Jr.
Deer, Philip James III.
Dennis, James L.
Denson, William D.
DesLauriers, S. Killeen
Dickins, John R. E.
Dickins, Robert D. Jr.
Dickson, D. Bud
Dillard, Daniel C.
Diner, Wilma C.
Dixon, Keith A.
Dodd, Doyne
Dodge, Eva F.
Dodson, William
Doucet, Marlon J.
Douglas, Warren M.
Downs, Ralph A.
Dungan, William T.
Durham, James W. #
Dwyer, Gregory A.
Easley, Edgar J.
Easter, Rex M.
Edge, Otis H.
Edmiston, Frank G.
Eidt, John
Eisenach, Robert J.
Eisner, Richard A.
Elders, M. Joycelyn

English, Jim
Evans, Billy
Evans, Scott
Eyre, Byron L.
Farmer, Joseph F.
Farque, Greg L.
Farris, Guy R. Jr.
Fazekas-May, Mary
Fernandez, Agustin
Ferris, Ernest J.
Fewell, Ronald D.
Fielder, Charles R.
Fields, Patrick R.
Finan, Barre F.
Fincher, Robert L.
Finkbeiner, Alex E.
Fiser, Martin
Fiser, Robert H. Jr.
Fiser, William P. Jr.
Fitzgerald, Charles
Fitzhugh, A. Stuart
Flack, James V. Jr.
Flanigan, Stevenson
Flanigan, William
Fletcher, Anthony
Fletcher, Elizabeth D.
Fletcher, Thomas M.
Flippin, Tony A.
Florez, James P.
Floyd, Bill G.
Fraiser, Lacy P.
France, Gene L.
Franklin, Gregory
Fraser, Eric A.
Fraser, James H. Jr.
Frazier, Cynthia
Frazier, George T.
Fuller, C. Dale
Fulmer, John M.
Galbraith, Robert C.
Gardner, Guy F.
Gardner, Kenneth
Gaston, Robert S.
Gettys, Joseph M. Jr.
Gibbs, Mark
Gibson, Gordon L.
Giglia, Anthony R. III
Giles, Wilbur M.
Gillespie, A. Tharp
Gillespie, James
Glenn, Wayne B.
Glidden, Michael L.
Glover, Lawson E. Jr.
Glover, W. Clyde
Golden, William E.
Good, Henry H.
Gordon, Vida H.
Gosser, Bob L.
Goza, George M. Jr.
Graham, G. Grimsley
Grant, Karen G.
Gray, Edwin F.
Green, Benny J.
Greenway, C. Don
Greer, Gerald S.
Greutter, John E. Jr.
Grimes, H. Austin
Growdon, James H.
Guggenheim, Frederick G.
Guin, Jere D.
Hagler, James L.
Hahn, Herbert
Hall, A. D.
Hall, A. David
Hall, R. Whit
Hampton, John R. III
Hankins, Edwin III
Hardberger, R. E.
Hardin, Ronald D.
Harger, C. Harold
Hargrove, Joe L.
Harper, Ernest H.
Harper, Gary E.
Harrendorf, Cagle
Harrington, Mariann
Harris, Donald R.
Harris, Ruben Michael
Harris, T. Stuart
Harris, William T.
Harrison, A. Vale
Harrison, Roy E.
Harrison, William E.
Harshfield, David Lee Jr.
Hawley, Harold B.
Hayden, William F.
Hayes, J. Harry Jr.
Hayes, Richard L.
Hayes, Sidney P.
Haynes, W. Ducote
Headstream, James W.
Heard, Jeanne K.
Hearnsberger, Henry G. Jr.
Hedges, Harold I.V.
Hedges, Harold H.
Hefley, Bill F.
Henker, Fred O. III
Henry, C. Reid Jr.
Henry, Charles R. Sr.
Henry, D. Andrew
Henry, G. Morrison
Henry, Guy
Henry, J. Charles
Henry, J. Forrest Jr.
Henry, Richard Y.
Henry, Robert A.
Henry, Robert L. Jr.
Henry, William T.
Herron, Jerry M.
Herron, John T.
Hickey, Joseph P.
Hicks, David
Hicks, David C.
Hill, Allen
Hodges, J. Timothy
Hodges, Lindy
Hodges, Steven C.
Hoffmann, Thomas H.
Holland, Jay D.
Hollenberg, Henry G.
Holloway, J. Douglas
Holmes, Harlan C.
Holt, L. Gordon
Holt, Stephen D.
Holton, Jerry C.
Hough, Aubrey J. Jr.
Houk, Richard
Howell, Coburn S. Jr.
Howell, Marsha T.
Hudson, Thomas F. III
Hughes, Ronald D.
Hundley, John M.
Hundley, Randal F.
Hutchins, Steven W.
Hutson, Harold G.
Jackson, J. Presley
Jackson, Morris A.
Jagannath, Sundar
Jansen, G. Thomas
Jay, Walter M.
Jefferson, Thomas T.
Jelovsek, Frederick R.
Johnson, B. Richard
Johnson, Ben D.
Johnson, Dianne Flowers
Johnson, Henry D.
Johnson, Philip H.
Johnston, Dale E.
Johnston, Thomas G.
Jones, Gail Reede
Jones, Garry L.
Jones, John C.
Jones, Kathleen C.
Jones, Robert D.
Jones, Roy
Jones, William N.
Jordan, F. Richard
Jordan, Randy A.
Joseph, Ralph F. II
Joseph, William Frank
Jouett, W. Ray
Joyce, John W.
Junkin, Ruth H.
Kaemmerling, Raymond E.
Kahn, Alfred Jr.
Kane, James J.
Keathley, Susan A.
Keeran, Michael G.
Kellar, Stanley L.
Keller, Alford W.
Kennedy, Charles H.
Kennedy, Eleanor E.
Kennedy, H. Frazier
Key, J. Michael
Kilgore, Reed W.
King, Michael T.
Kirchner, Jeffrey
Kittler, Fred J.
Kizziar, Jim C.
Knox, Michael F.
Kolb, Agnes J.
Kolb, W. Payton
Koonce, Thomas W.
Kovaleski, Thomas M.
Kozberg, Oscar
Krulin, Gregory S.
Kumpuris, Andrew G.
Kumpuris, Dean
Kumpuris, Frank G.
Kuykendall, Robert
Kyle, Joan E.
Kyser, James F.
Laakman, Robert W.
Lambert, Robert A.
Landers, James H.
Landgren, Robert C.
Lane, John W.
Lang, Nicholas P.
Langston, Harold D.
Laurenzana, Donald A.
Lawson, Mason G.
LeNarz, LeRoy A.
Lea, Allen K.
Lehmberg, Robert W.
Leibovich, Marvin
Leonard, Donald G.
Lewis, Derek
Lewis, W. Sexton
Lile, Henry A.
Lincoln, Ben M.
Lipke, Jay M.
Livingston, Richard Lee
Loebl, Edward C.
Logan, Charles W.
Love, Tommy L. Jr.
Lowe, Betty A.
Lucy, Dennis D. Jr.
Ludwig, Frank R.
Lyons, Virgle E. Jr.
Mabrey, William
Magie, Stephen K.
Malak, F. A.
Mallory, John A.
Maloney, F. Patrick
Mann, R. Jerry
Markland, Gary S.
Marks, Stephen R.
Martin, Richard H.
Marvin, Peter
Mason, J. Zachary
Mason, William L.
Matthews, Joseph W.
Matthews, Robert R.
McAdoo, Hosea W. Jr.
McCarthy, Richard E.
McCluer, Shirley M.
McConnell, John D.
McCowan, Timothy
McCracken, Gail Ann
McCracken, John D.
McCrary, George A.
McCutcheon, Frank B. Jr.
McDonald, James Ewell
McDonald, Judy
McDonald, William Glen
McGowan, Robert J. Jr.
McGrew, Robert N.
McGriff, Lloyd
McKelvey, K. David
McKenzie, Charles N. #
McKinney, Carl N.
McKnight, C. Allen
McMillin, F. Lamar Sr.
McNair, James R.
McNee, Valerie
Meacham, Donald F.
Meador, Annette Parker
Means, Paul N.
Mendelsohn, Lawrence A.
Metrailer, James A.
Meziere, Tom
Middaugh, Riley Ann
Miller, Forrest B. Jr.
Miller, Frank C.
Miller, Raymond P. Sr.
Milner, E. L.
Mitchell, George K.
Mizell, Walter S.
Money, Wandal D.
Mooney, Donald K.
Moore, Burton A.
Moore, J. Malcolm Jr.
Moore, Michael
Moore, Rex N.
Moore, Robert B.

Morris, Paula
Morris, W. Dale
Morris, Woodbridge E.
Morrison, Debra F.
Morrison, James R.
Morse, James C.
Morton, William J.
Mulhollan, James S.
Mundie, J. Ryland
Murphy, Bruce
Murphy, James E. Jr.
Murphy, Joseph
Murphy, Randolph
Murphy, Robert
Murphy, Tena
Nagel, Fred G.
Nash, John C.
Neale, David
Nelson, Alvah J. III
Nelson, Carl L.
Nestrud, Richard M.
Newsum, Jon Kirby
Nix, Richard A.
Nokes, Steven
Nolen, James E.
Norton, George A.
Norton, Joseph A.
O'Neal, Walter H.
Oates, Gordon P.
Oddson, Terrence A.
Ogden, Mahlon D.
Oglesby, Walter R.
Osam, Patrick N.
Osteen, Paul
Ozment, Kerry L.
Padberg, Frank T.
Padilla, Fernando
Pappas, James J.
Parker, J. Mayne
Parkhurst, James
Parmley, Tim
Parnell, Clifton L. III
Paulus, Thomas E.
Pearce, Charles
Peeples, R. Earl
Peters, John E.
Peters, Phillip J.
Petursson, Gissur J.
Phillips, Bert L.
Phillips, Charles E.
Phillips, James R.
Pike, John D.
Pledger, Norman R.
Pollard, Arlee E.
Pope, Norton A.
Porter, Robert A. Jr.
Potts, Jerry L.
Power, Robert C.
Prather, Jerry L.
Price, Ben O.
Pringos, Andrew A.
Purdy, Harold D.
Pyle, Hoyte R. Jr.
Quirk, J. Gerald
Ragsdill, Mary L.
Ransom, John M.
Raque, Carl J.
Rasch, James R.
Rector, Nancy F.
Reding, David L.
Redman, John F.
Reed, Ewing C. Jr.
Reese, William G.
Regnier, George G.
Reid, Gene W.
Rice, Charles
Riddle, John F. Jr.
Riegler, N. W. Jr.
Riley, William H.
Ritchie, Robert Ross
Roberson, Michael C.
Roberts, Thomas
Robinson, Paul F.
Rodgers, C. Dudley Jr.
Rodgers, Charles H.
Rooney, Thomas P.
Rosenbaum, Carl A.
Ross, Ashley Sloan Jr.
Ross, Cynthia
Ross, Robert W.
Ross, S. William
Rothert, Frances C.
Rounsaville, Harry L.
Roy, F. Hampton
Ruggles, Dwayne L.
Runyan, William A.
Rutledge, William L.
Saer, Edward H. III
Sain, Mary K.
Saltzman, Ben N.
Satre, Richard W.
Satterfield, John V. III
Schock, Charles C.
Schratz, Bruce E.
Schroeder, George T.
Schultz, John C.
Schwander, L. Howard
Scruggs, Jan W.
Searcy, Robert M.
Seibert, Joanna J.
Seibert, Robert
Selakovich, Walter G.
Selby, John H. Jr.
Shannon, Robert F.
Shock, John P.
Short, Harold K.
Silvoso, Gerald R.
Simmons, Orman W.
Simpson, N. Henry Jr.
Sims, James M.
Singleton, L. Gene
Sipes, Frank M.
Skokos, C. Kemp
Slater, John G. Jr.
Slaven, John E.
Slayden, John E.
Sloan, Fay M.
Sloan, James M.
Smart, Douglas F.
Smith, Aubrey C.
Smith, Charles
Smith, David E.
Smith, Douglas B.
Smith, G. Richard Jr.
Smith, James L.
Smith, Mose III
Smith, Purcell Jr.
Smith, Thomas J.
Smith, Thomas W.
Smith, Tom
Somers, A. Jack
Sorrells, R. Barry
Sotomora, Ricardo F.
Spitzberg, Irving Jr. #
Squire, Arthur E. Jr.
St. Amour, Thomas E.
Stair, J. Michael
Stallings, Walt
Stanley, Joe P.
Steele, William L.
Stefans, Vikki Ann
Stemberg, Jack J.
Stone, Van D.
Storeygard, Alan R.
Stotts, John R.
Strauss, Alvin W. Jr.
Strauss, Mark A.
Strode, Steven W.
Stroope, George F.
Stuckey, James G. Jr.
Studdard, James D.
Sturdivant, Stephen
Suen, James
Sulieman, J. Samir
Sullivan, Charles D.
Sullivan, Jan R.
Sundermann, Richard H.
Swindoll, Bryant S.
Tabor, Marcella A.
Tamas, David E.
Tanner, James A.
Taylor, David R.
Taylor, Eugene H.
Tedford, John G.
Teeter, John A. #
Teplick, Steven
Texter, E. Clinton Jr.
Thomas, A. Henry
Thomas, Jerry L.
Thomas, Kathy
Thomas, Peter O.
Thompson, A. Reed
Thompson, Dola S.
Thompson, John R.
Thompson, S. Berry Jr.
Thorn, G. Max
Tilley, Steve
Tirado, Emilio
Towbin, Eugene J.
Tracy, Phillip A.
Tranum, Bill L.
Trussell, Thomas W.
Tseng, Jyi-Ming
Tucker, R. Stephen
Tucker, W. Everett
Valentine, Robert G. Jr.
Vaughter, W. Roger
Velez, Louis D.
Vogel, Robert G.
Wade, William I. Jr.
Wagoner, Jack
Walker, Ronald
Walt, James R.
Ward, Harry P.
Ward, Joseph P.
Ward, Thomas
Warford, Walton R.
Watkins, Charles J.
Watkins, John G. Jr.
Watkins, John G. III
Watkins, Larry S.
Watson, C. Robert
Watson, Daniel W.
Weber, Edward R.
Weber, James R.
Weber, Michael J.
Weiss, Gerald N.
Welch, Samuel Bradley
Wellborn, James C. Jr.
Wellons, James A. Jr.
Wende, Raymond A.
Wenger, Carl E.
Westbrook, Kent C.
Westerfield, Frank M. Jr.
White, Faber A.
White, Oba B.
White, Ronald Lynn
Wilkes, Elbert H.
Wilkes, T. David I.
Williams, Alonzo D.
Williams, C. David
Williams, G. Doyne Jr.
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Williamson, Stephen
Wilson, Elaine
Wilson, Frances C.
Wilson, Frank J. Jr.
Wilson, Ivan
Wilson, James W.
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Wilson, R. Sloan
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Workman, W. Wayne
Wortham, Thomas H.
Wright, Ruel N.
Yocum, John
Young, Douglas E.
Zelnick, Paul

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Cash, Ralph D.
Cheadle, Matt G.
Coker, S. Dale
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Cornwell, Samuel L.
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Hill, Edward B.
Hill, Howell V.

Hogue, F. Paul
Hood, C. Ted
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Ramsay, Rex C. Jr.
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Sudderth, Brian F.
Taggart, Sam D.
Thibault, Frank G. Jr.
Thomas, Bill R.
Thompson, Steven M.
Thorn, Harvey Bell Jr.
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Viner, Donald L.
Wagner, Taylor
Watson, Kirk D.
Wright, John D.

Sebastian

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Alberty, Joe
Anderson, Paul
Armstrong, Sinclair Jr.
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Atkins, Jimmie G.
Axelsen, Nils K.
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Barker, Robert Jr.
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Barr, Marilyn
Barry, James M. Jr.
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Berryhill, Richard E.
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Brown, Byron L.
Brown, James A.
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Carson, Randall L.
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Cassady, Calvin R.
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Hoge, Marlin B.
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Holmes, Williams C. Jr.
Hornberger, Evans Z. Jr.
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Huskison, William T.
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Jefferson, Thomas C.
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Kelsey, J. F.
Kennedy, Virgil N.
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Kocher, David B.
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Kramer, Ralph G.
Kutait, Kemal E.
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Lewing, Hugh S.
Lilly, Ken E.
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Still, Eugene F. II
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Sevier

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Tommey, Robert C.
Turnbow, R. L.
Vasan, Srini
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Henry, L. Murphey #
Henry, Morriss M.
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Higginbotham, William
Hudson, Loyde H.
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Hutson, Martha
Inlow, Charles W.
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Knox, D. Luke
Lacy, Hilton R.
Lesh, Ruth E.
Lesh, Vincent O.
Litton, Eva W.
Lushbaugh, Harmon
Magness, C. R.
Markland, Linda A.
Martin, William C.
Mashburn, James D.
McAlister, Joseph H.
McAlister, Mitchell S.
McAllister, Max F.
McBee, Sara
McDonald, James E. II
McEvoy, Francis E.
McGowan, William
McNair, William
Miller, Charles H.
Mills, William C. III
Moore, Arthur F.
Moore, James F.
Murry, J. Warren
Nettleship, Mae B.
Northum, Charles
Nowlin, William B.
Ortego, Terry J.
Painter, Monroe B. #
Pang, Robert
Park, John P.
Parker, Joe C.
Parker, Lee B. Jr.
Patrick, James K.
Petrino, Robert A.
Pickett, James D.
Power, John R.
Proffitt, Danny L.
Rhodes, David
Riddick, Earl B. Jr.
Riner, Dan M.
Rogers, David L.
Romine, James C.
Rouse, Joe P.
Rudko, Michael
Runnels, Vincent B.
Sexton, Giles A.
Shaddox, T. Stephen
Sharp, Jim D.
Siegel, Lawrence H.
Singleton, E. Mitchell
Sisco, Charles P.
Smith, Austin C.
Thomas, Ellidee D.
Titus, Janet L.
Tuttle, Larry D.
Ward, H. Wendell
Weed, Wendell W.
Weiss, John B.
Wheat, Ed Jr.
Whiting, Tom D.
Wilson, Robert B. Jr.
Wood, Jack A.
Woods, Elizabeth Ann

White

Asbury, Dale W.
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Bell, John
Blue, Glen T.
Blue, Leon R.
Brown, Arnold R.
Brown, Terry Mac
Citty, Jim C.
Collier, Steven F.
Covey, David C.
Davidson, Daniel
Edwards, Hugh R.
Elliott, Robert E.
Farrar, Henry C.
Fincher, S. Clark
Formby, Thomas A.
Gardner, Jack R.
Gibbs, William M. III
Golleher, James H.
Green, Terry G.
Hatfield, David L.
Henderson, John C.
Jackson, Clarence W.
Johnson, David M.
Joseph, Eugene A.
Justus, Michael G.
Killough, Larry R.
Kinley, J. Garrett
Koch, Clarence W. Jr.
Lowery, Benjamin R.
Lowery, Robert D.
Maguire, Frank C. Jr.
McAdams, Edward L.
McCoy, James R.
Meacham, Kenneth R.
Miedema, Edward B.
Nevins, William H.
Norris, E. Lloyd
Ransom, Clarence E. Jr.
Rasberry, Ronnie D.
Rodgers, Porter R. Jr.
Sanders, John K.
Schwartz, Stanley S.
Shultz, Sam L.
Simpson, James A.
Smith, Bernard C.
Smith, Bob W.
Stinnett, J. L.
Tate, Sidney W.
Weathers, Larry W.
White, William D.
Williams, W. Curtis

Woodruff

Hendrixson, Basil E.
Rowe, James E.

Yell

Bull, L. J.
Harris, Walter P.
Hodges, Jerry F.
Luker, Jerome H.
Martin, Damon G. H.
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Ring, Gene D.
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Anding, Brian S.
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Banerjee, Bhaskar
Barnes, Charles
Barnes, Gregory
Baskin, Barry
Bauer, David
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Beaton, Susan
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Beck, Howard
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Beck, Suzanne
Beene, Stephen
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Brown, Pamela
Bryles, Jeffrey
Bui, Lai T.
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Cauley, David B.
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Chen, Bai-Hsiun
Cleveland, Elton
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Collis, Curtis
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Courtney, Willis Jr.
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Crabtree, Herbert
Cross, Thomas
Croswell, Kent
Crouch, James Jr.
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Crowe, Michael
Darville, Lee A.
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Floyd, Rebecca
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Green, R. Clark
Greene, Lyndon
Grimes, Kimberly
Grisham, Dannetta
Grohman, Tyrrel C.
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Guresky, Peter
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Hurlbut, Kevin
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Jeffery, James
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Johnson, Donna
Jones, Stacie
Karing, Michael
Kassam, Mary-Jane B.
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Kent, William
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Lawton, Steven
Lefler, Stephen F.
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Lyle, Robert
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Martin, Marian
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Norman, Charles
Otovo, Earnestine
Owen, Kip
Padilla, Rafael
Palesano, Richard
Parker, Lawrence
Parro, Elizabeth
Petersen, Michael S.
Petrus, Gary M.
Petty, Jay
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Phillips, Laura
Pippenger, Janet
Plott, R. Todd
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Porter, Martin
Price, Claire
Pruitt, Tad
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Reddy, Joseph B.
Reese, John
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Reis, Ivory
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Ringold, Mark
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Robbins, Mark
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Robertson, Daniel M.
Robertson, Ronald
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Russell, James B.
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SanPedro, Gerardo S.
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Wiseman, Eve J.
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Wood, Margaret
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Wylie, Paul

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Young-Shumate, Linda

Students

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Allen, Gregory
Allison, Russell
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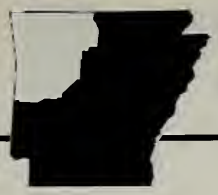


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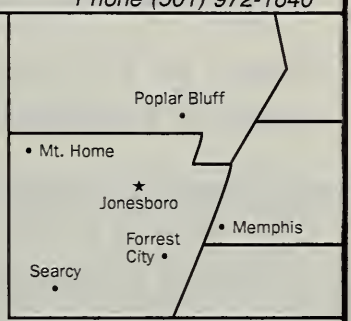
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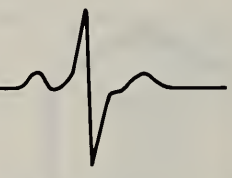
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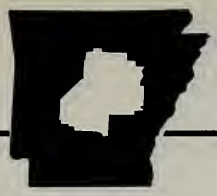
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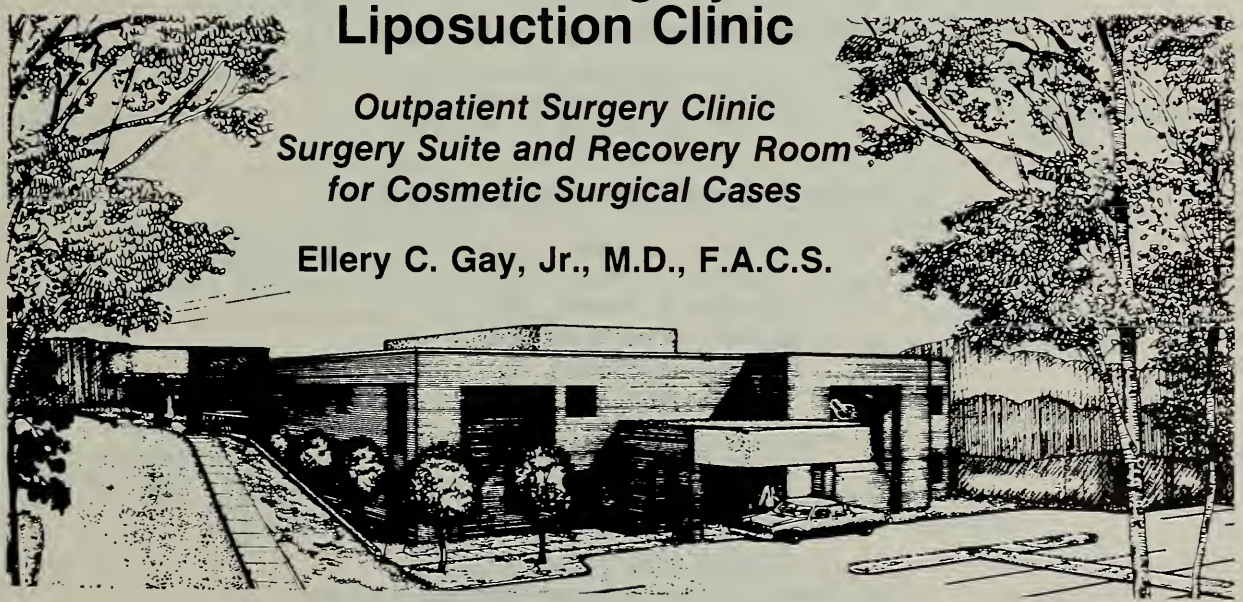
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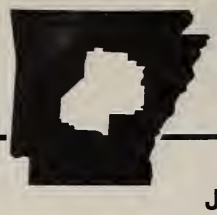
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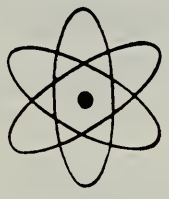
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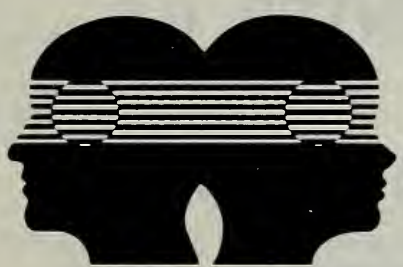
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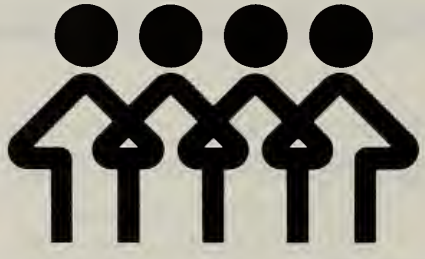
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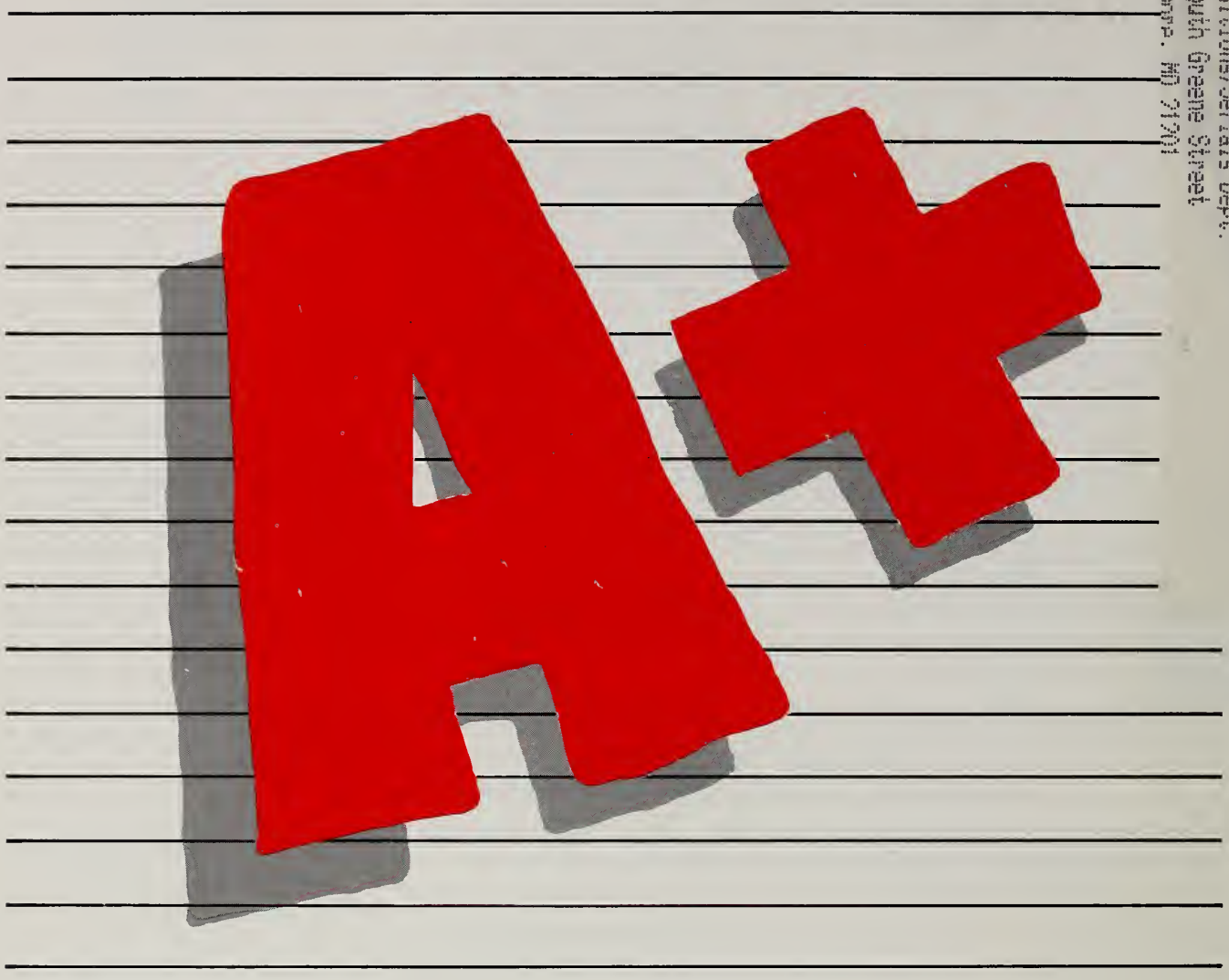
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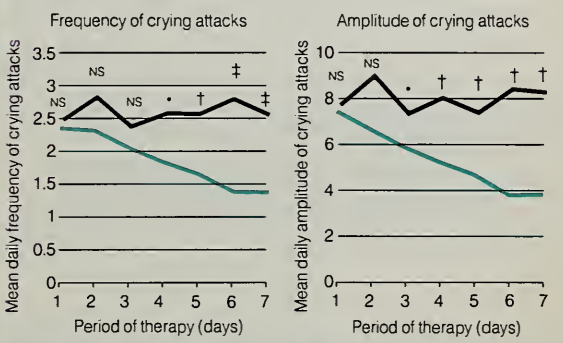
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On Our Cover:

The cover photo was taken by Kathy Hinson of Little Rock. She works as a volunteer at the Little Rock Zoo where she is able to photograph animals in situations that are uncommon to their species. She photographed this tiger up in the top of a tree.

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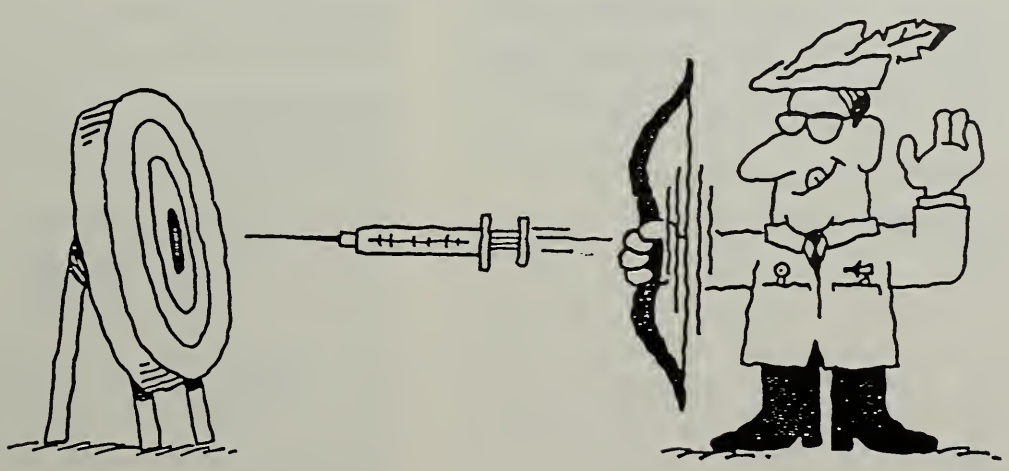
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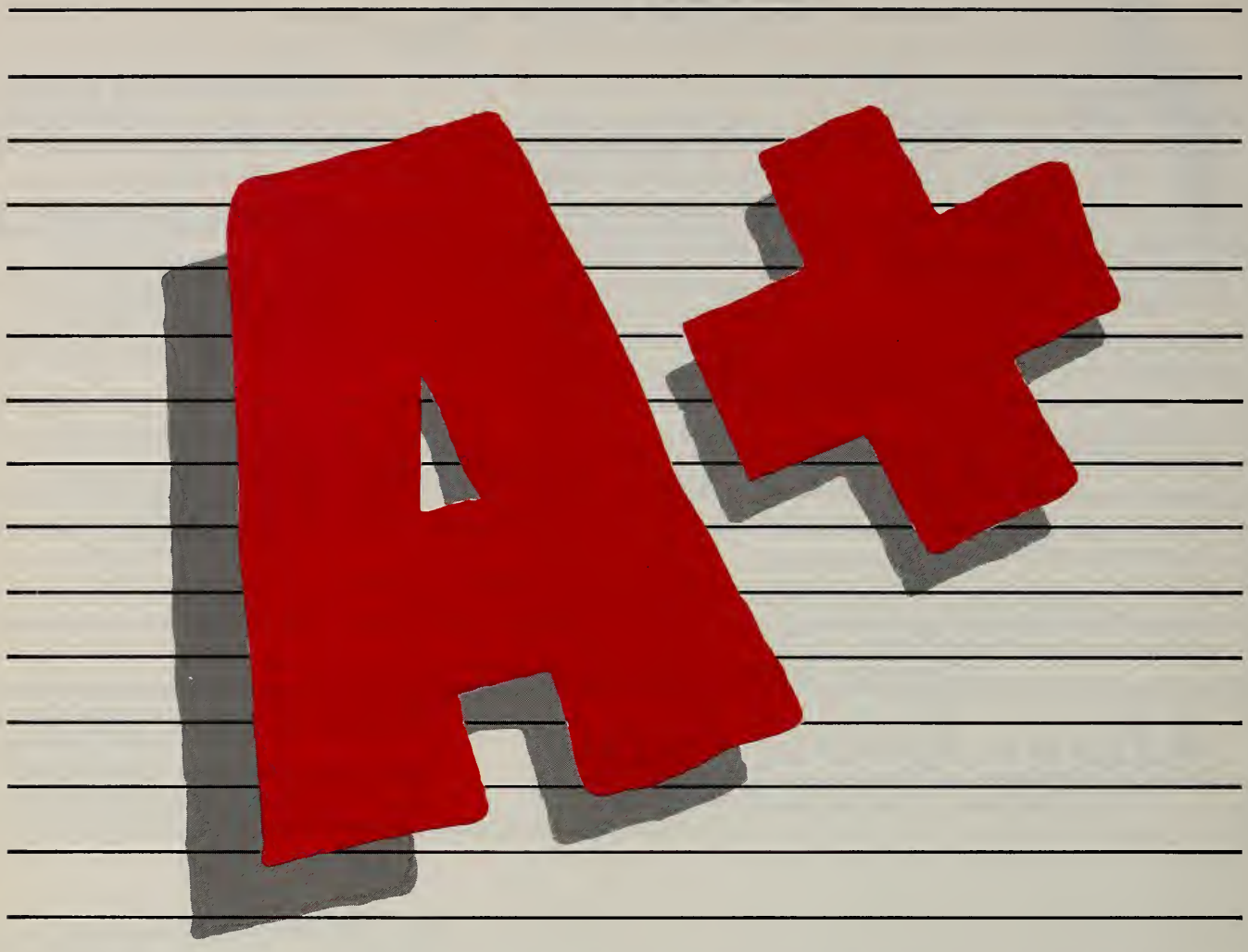
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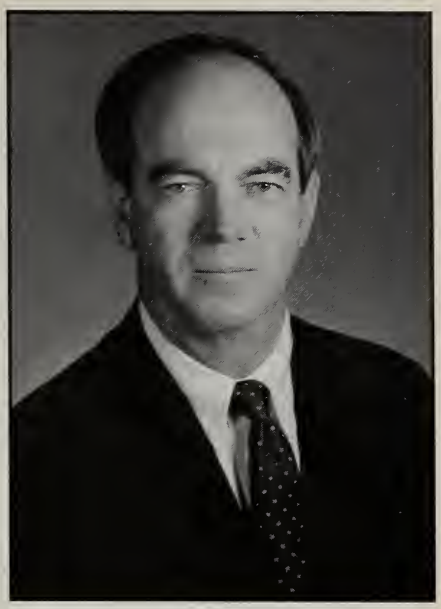
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William N. Jones, M.D.
President-Elect
Arkansas Medical Society
Chairman, Committee on AIDS

All of us who have taken on the responsibility of leadership from time to time have been critical about some aspect of the AMA and AMS. It behooves us to change what we perceive as wrong or poor policy because, like it or not, Congress and our state legislature look to those bodies for advice and direction in matters that concern the public health and how medicine is, and will be, practiced.

I attended the 138th Annual Meeting of the American Medical Association in Chicago, June 18-22, 1989. Since it was my first experience at that level of organized medicine, I was excited and at the same time somewhat in awe of the proceedings. I attended as the President-Elect of the Arkansas Medical Society so I could become informed about the issues and concerns of organized medicine and be aware of the leadership's approaches to those problems.

Any member of the AMA may attend the Annual and Interim Meetings and address any item of business to come before the House of Delegates. The forum that allows this is the reference committee. Every report or resolution to ultimately be considered by the House of Delegates is first discussed in a reference committee.

The agenda of the House of Delegates included many resolutions pertaining to Human Immunodeficiency Virus (HIV). At the annual session of the Arkansas Medical Society, the AMS House of Delegates endorsed a resolution previously adopted by the Medical Society of the State of New York which declared that the AMA House of Delegates should formally take the position that AIDS is a communicable/sexually transmissible disease and that states should apply the same public health measures to contain the HIV epidemic as are taken to control the spread of other communicable/sexually transmissible diseases. Appropriate notification of the AMS endorsement was sent to the AMA, the Medical Society of the State of New York and our senators and congressmen.

In Chicago at the June meeting, I spoke in Reference Committee E in support of the New York Resolution. I also pleaded with the reference committee to recommend to the House of Delegates the endorsement of reportability of HIV sero-positivity for the purpose of contact tracing and partner notification, important measures to take to slow the spread of the HIV epidemic. The opposition which included the Surgeon General of the United States and civil libertarians, true to form, stated that such policies would lead to breach of privacy and confidentiality of the infected index person. Additional arguments raised suggested that since there was no effective treatment there was nothing to be offered the person found to be HIV infected, that such a program would lead to decrease in volunteer testing and would not be cost effective.

In rebuttal, I told the reference committee that the purpose of those time proven strategies was to make it possible for the infected person to be counseled on all aspects of the infection and the determination of his or her sexual and drug contacts so they might be interviewed, counseled and offered testing. The process known as contact tracing has been an historically proven technique for the control of sexually transmitted diseases for over 40 years and in large measure contributed to the control of syphilis and gonorrhea.

Regarding privacy and confidentiality of the infected index person, one should also consider the right of the

previously uninformed contact. The rights of the individual to privacy and confidentiality are protected in any sexually transmitted disease program, however, the bottom line is that individual rights have to be second consideration to the rights of the public to be protected from the spread of this fatal viral epidemic.

For more than two years we heard anecdotal stories and information from experienced therapists of HIV disease that AZT lengthened the interval between infection and clinical disease. Published peer reviewed articles now have established this as fact.

In states where reporting of HIV sero-positive status is law or regulation, such as Arkansas and Colorado, volunteer testing has not been affected.

Ten resolutions pertaining to AIDS issues were debated in Reference Committee E. Subsequently the House of Delegates instructed the Board of Trustees to consider those resolutions while it updated the AMA Policy on AIDS - Report YY (1987) - and report back at the Interim Meeting in December 1989. This resulted in Report X (I-89) of the Board of Trustees - AMA HIV Policy Update as prepared by members of the staff of the AMA and the Council on Scientific Affairs.

Report X was a significant improvement in the 1987 AMA AIDS Policy but it was, I felt, inadequate in at least two major areas. Its statement on contact tracing and partner notification was weak and there was no consideration, pro or con, on reportability of HIV sero-positivity.

"The seeds of a wonderful project could be right under your nose."

The Interim Meeting of the AMA House of Delegates was held in Honolulu, December 3-6, 1989. The various reference committees began their deliberations on the morning of December 4th. I attended Reference Committee E which had received Report X for discussion.

Just before the committee was called to order, I renewed acquaintance with Drs. Brian and Lawrence McNamee. These brothers have degrees in medicine and law and have published a book and several articles on AIDS issues. We discussed various deficiencies in Report X and how we might work to correct them. I suggested that we sit in different areas of the room and speak from each of the three microphones to create the appearance of general support for our points of view. Although the dress of the meeting was casual, we all wore dark suits and red ties! I also recommended that we allow the opposing viewpoint to be expressed first so we could both rebut and make our points in the middle and end of discussions. We also agreed not to speak too often in order to be listened to when we wanted to suggest a significant change in the document.

Report X of the Board of Trustees - AMA Policy Update - was 25 pages long and included 35 major recommendations, each of which had subparts A, B, C, etc. Each recommendation was discussed pro and con starting about 9:30 in the morning and continuing for the next five hours. Although I had much interest in the early discussions, I deliberately waited for the subject of contact tracing and partner notification on page 21.

Recommendation 29A stated, "That AMA urge all communities to consider implementing a contact tracing and partner notification program to warn unsuspecting sexual or needle-sharing partners who might have become HIV infected."

Although I was pleased the report addressed contact tracing and partner notification, I was not pleased with the wording of the recommendation. I felt the words "urge to consider" were not strong enough direction.

The same old arguments in opposition to contact tracing and partner notification that had been raised in Chicago were again stated by persons of civil libertarian orientation and by representatives of the United States Public Health Service (USPHS).

I then addressed the committee as follows:

> "Mr. Chairman: We have been debating particulars of this proposed policy for hours but there is one glaring deficiency in this report. It fails to recognize the need for reporting HIV sero-positive persons to the health departments of the 50 states. I rise to request the AMA Board of Trustees Report X be modified to include a section supporting the requirement of reporting HIV sero-positive persons. If we do not require the reporting of HIV sero-positive individuals, there is no way for an adequate contact tracing and partner notification program to be carried out and have a positive effect on slowing the spread of the epidemic.
>
> It is past time for the AMA to take a firm position of leadership and emphatically state the importance of HIV sero-positivity reportability and individual contact tracing. Everyone in this room must know by now and understand that HIV infection is a continuum of disease. To endorse reporting of AIDS cases and not HIV infection is inconsistent policy.
>
> The rights of the individual to privacy and confidentiality have to be second consideration to the right of the public to be protected from this fatal viral epidemic."

The subsequent applause, both hand clapping and verbal, was overwhelming! But that did not deter further comment against this point of view from several persons including a member of USPHS and Dr. Lonnie Bristow, representing the AMA Board of Trustees. Among other things, he said that the trustees had considered this point and they felt it was not a timely recommendation.

Table 1
INTRODUCED BY THE ARKANSAS DELEGATION
AMENDMENT - REPORT OF REFERENCE COMMITTEE E

Recommend the following Substitute Recommendation 29-A on page 22, lines 19-22 of Report X of the Board of Trustees:

Recommendation 29-A:That the AMA strongly recommends a system for contact tracing and partner notification for unsuspecting sexual or needle-sharing partners who might have been HIV-infected should be established in each community.

Recommend the following be added as Recommendation 29-E on page 22, line 43 of Report X of the Board of Trustees:

Recommendation 29-E: That the AMA strongly recommends the reportability of HIV sero-positive patients to the departments of health of the 50 states for the purposes of contact tracing and partner notification.

The profound show of support for my viewpoint suggested to me that the silent majority was fed up with being intimidated and mesmerized by the vocal civil libertarian - homosexual advocate minority with its self-centeredness and calloused disregard for the health of others. It was past time to employ the same public health measures in the HIV epidemic as are used in other communicable and sexually transmissible diseases.

By this time all of the reference committees had concluded their hearings, and Speaker, Dr. John Clowe and Vice Speaker, Dr. Daniel Johnson were concerned that Reference Committee E might not finish its agenda until late in the night with over 43 more resolutions to be discussed. They suggested that the reference committee be divided into two sections, one to continue discussing AIDS issues and the other for the remainder of the agenda. Their suggestion got a resounding "No" vote. We then continued discussion of the last paragraphs of Report X.

The next resolution to be considered, Resolution 132, stated "Resolved, that the American Medical Association House of Delegates encourage state legislation to establish requirements for reporting and case follow-up for serious contagious diseases, to include AIDS nationwide."

I suggested to the reference committee that it should consider changing the word "AIDS" to the words "HIV infection." Although I would rather have this type recommendation in the overall policy statement, this change in Resolution 132 would have the same desired effect I sought.

I took the opportunity to point out to the reference committee, that although no votes are taken in reference committees, the sentiment in favor of the reportability of HIV sero-positive status, as expressed by the applause I had received, was greater in volume than the summation of all the applause other issues had received since we began deliberating that morning. This also received applause!

In the hallway following the adjournment of the reference committee, I was approached by Dr. Roy Schwarz, Assistant Executive Vice President of the AMA, who complimented me on my endeavor and pointed out that for the first time there seemed to be significant support for this issue. He told me this subject had received heated debate in the committee which he chaired that was responsible for composing Report X.

Monday evening I met with the Dermatology Section and reviewed for its members the deliberations on Report X. It was suggested by that group of eleven physicians that I seek to express my viewpoint on the floor of the House of Delegates. They further suggested the mechanism would be to ask one of our state's alternate delegates to let me have his position temporarily and that I should then ask one of our delegates to give me his seat when Report X was under consideration by the House of Delegates. At this meeting I was assured that each of them would solicit support of their individual state delegations in behalf of my positions.

I later talked with several experienced delegates and found out that the suggestion of my dermatologic colleagues to become a temporary delegate was seldom, if ever, done and would not likely be possible.

Late that night I received a phone call from Brian McNamee who told me he had a conversation with a member of Reference Committee E and that we would be pleased with their report. I felt elation, and also relief, that no further effort on my part would be needed.

The report of Reference Committee E was not available until late in the afternoon, Tuesday, December 5th. Unfortunately, the reassurance that Dr. McNamee had received was not forthcoming in the report. I felt frustration. Do we wait months or years longer to get this done?

The reference committee report stated, "Based upon the testimony heard, the reference committee strongly recommends that in subsequent AIDS updates the Board specifically address the need for reportability of HIV sero-positive patients to public health agencies...."

This presumably was put in to pacify us but it made me want to continue the challenge.

To further diffuse the issue, the reference committee did recommend that Resolution 132 delete the word "AIDS" and add the words "HIV infection" as I had suggested in the hearing.

I decided to contest this further, and during an afternoon recess, I found the Speaker and Vice Speaker in the hallway. I was aware of the parliamentary point - Privilege of the Floor - so I asked them about how I could receive it. They, at first, were hesitant saying it usually is used for special addresses to the House of Delegates. When I explained my dilemma, they agreed that if I could get a delegate to ask the Speaker, at the appropriate time, I would be allowed two minutes to state my case.

"Probably, the most startling comment came from Brian McNamee when he pointed out that I came to the meeting as a nondelegate with an ax to grind, was given the rarely used Privilege of the Floor, and successfully changed AMA policy."

At this point, I sought the help and advice of Dr. A.E. Andrews. Dr. Andrews agreed to ask the Speaker for my Privilege of the Floor on Wednesday morning when Report X was to be presented. Together we composed the following amendments. The first amendment would substitute a much stronger endorsement of contact tracing and partner notification for the weak statement included in the report. The second amendment would add a section to Report X recommending the reportability of HIV sero-positivity rather than have such a recommendation contained in a separate resolution. We then presented our amendments, in behalf of the Arkansas delegation, to the AMA staff who printed them and placed them on the desks of the delegates Wednesday morning (see Table 1).

Tuesday evening I met with the McNamees and told them of my plans. They offered to lobby Wednesday morning for the Arkansas amendments in several delegations, including Ohio and New York.

After my planning session with the McNamees, Ruthie and I had dinner in the Golden Dragon Restaurant. As the meal ended, we were presented with the traditional fortune cookies. Although I am not one who wishes on stars, nor consults with a palmist or shaman, my fortune cookie message was very reassuring. It read, "The seeds of a wonderful project could be right under your nose." How prophetic!

After dinner, I prepared the statement I hoped to make to the House of Delegates Wednesday morning. Several revisions later, I got the statement down to a two minute presentation.

By Wednesday morning, everyone at the meeting was ready to finish up the deliberations as quickly as possible. Debate was to be limited and I was concerned that I might not get the chance to speak. On the way to the House of Delegates meeting, I met Dr. Schwarz who asked me if I was happy with the report of the reference committee. I explained my displeasure. He told me he had seen the report in rough draft and suggested the original draft would have been more to my liking.

Before he was to present the report of Reference Committee E, I found the Chairman, Dr. Carl Evers, and told him I was disappointed with the report and I planned to speak for reporting of HIV sero-positive status. He looked surprised and said, "We gave you what you asked for in Resolution 132" and I said, "Yes, but it should have been incorporated as a part of Report X." At this moment a young gentleman stepped up to us and said, for both of us to hear, "It is a done deal, the trustees will not fight the Arkansas Amendments. Lonnie Bristow will speak in favor of adoption of the amendments." Oh what a feeling! I could smell success!

Finally, we arrived at the House of Delegates consideration of Report X. The Speaker chose to take each recommendation one by one. At the appropriate time, Dr. Andrews asked the Speaker to consider the two Arkansas Amendments and for me to be given the opportunity to speak in behalf of the Arkansas Delegation in support of the amendments. Privilege was given and I made my two-minute prepared speech (see page 349).

I was pleased with the enthusiasm and the volume of applause that followed. Immediately, endorsement came from the delegations from Mississippi, New York, Virginia, West Virginia, Florida and the delegate from the American Academy of Dermatology. Opposition was basically from California and again, the USPHS spokesman was negative in his remarks.

A substitute motion was made to refer this issue back to the Board of Trustees. The vote to refer was by voice and the Speaker hearing the vote said he was in doubt of the response and asked for a second voice vote. There was then overwhelming vote to not refer.

At this point, I felt passage of the Amendments was assured. Belated endorsements were then given for the Board of Trustees by Dr. Bristow and for the reference committee by Dr. Evers.

Immediately, the Speaker called for a voice vote on the two amendments and there no audible opposition. The amendments had passed!

I made my way to the side of Dr. Bristow and thanked him for the Board's support.

As the meeting ended, the Arkansas Delegation received much praise and thanks from our colleagues.

"Mr. Speaker - Members of the House of Delegates:

I am William Jones, Chairman of the Arkansas Medical Society's Committee on AIDS, member of the Governor's Advisory Committee on AIDS, and President-Elect of the Arkansas Medical Society.

On Monday, the debate in Reference Committee E over each aspect of Report X was to be expected. Basically, Report X of the Board of Trustees is a significant improvement of Report YY-87.

In June, I pleaded with Reference Committee E to ask the House of delegates to endorse contact tracing and partner notification. Subsequently, all of the resolutions on AIDS were referred to the Board of Trustees to update the HIV policy of the AMA. Most of those resolutions supported contact tracing, partner notification and the reporting of HIV sero-positive persons.

Report X endorses contact tracing and partner notification. However, there is one glaring deficiency in the report. Namely, it fails to recognize the need for reporting HIV sero-positive persons to the health departments of the various states. AIDS is reportable in all 50 states. HIV sero-positive status is reported in many states and others are considering such legislation at this time. It must be remembered that HIV infection is a continuum of disease leading to death. The infected person is infectious to others from very early in his or her infection.

For too long we have failed to apply the same public health measures to contain the HIV epidemic as are taken to control the spread of other communicable and sexually transmissible diseases. This has resulted in over 65,000 reported deaths in this country. How many more lives have to be lost before we take a stand that, every physician in this country knows, should have been taken several years ago? It is past time for the American Medical Association to take a firm position and emphatically state the importance of reporting HIV sero-positive patients, contact tracing and partner notification. Concerns about the occasional breach of privacy and confidentiality of one individual have to be second consideration to the right of the public to be protected from this fatal viral epidemic.

The longer we delay taking this position, the wider spread the epidemic and the greater the tragedy in loss of lives that could be saved by these measures.

I urge you to vote affirmatively on the two amendments to Report X."

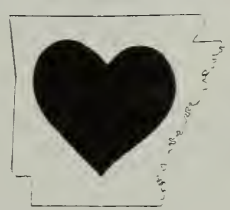
-Dr. William Jones

Probably, the most startling comment came from Brian McNamee when he pointed out that I came to the meeting as a nondelegate with an ax to grind, was given the rarely used Privilege of the Floor, and successfully changed AMA policy.

Later that evening, as the thrill of achievement began to subside, I began to think about the ultimate impact this change in AMA policy would have on laws and regulations throughout the country. Thousands of lives will be saved as this policy is put into action. I want everyone who has been involved in the Committee on AIDS activities since May 1987 to feel a part of and take pride in this accomplishment. Not just members of the committee who have inspired and nurtured each other, but the AMS staff, the medical students of F.A.T.E. and all the physicians and auxilian volunteers. It is the summation of all their support and participation that brought about this success.

All of us who have taken on the responsibility of leadership from time to time have been critical about some aspect of the AMA and AMS. It behooves us to change what we perceive as wrong or poor policy because, like it or not, Congress and our state legislature look to those bodies for advice and direction in matters that concern the public health and how medicine is, and will be, practiced.

There is a system and it works but we must be willing to do the homework and sacrifice the time and energy to work the system.



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AIDS IN ARKANSAS 1989
January 1 - December 28, 1989

Total number of cases reported	79
Number of deaths	37

CASES BY SEX

Male	69
Female	10

CASES BY RACE

White	57
Black	21
Other	1

CASES BY RISK GROUP

Homosexual/Bisexual	50
Homosexual & IV Drug User	5
IV Drug User	10
Hemophiliac	1
Transfusion	3
Heterosexual (Contacts)	8
NIR#	2

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	1
20 - 29	23
30 - 39	41
40 - 49	7
50 - 59	6
60 or more	1

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	31
Kaposi's Sarcoma	3
Pneumocystis Carinii and Kaposi's Sarcoma	0
Other Diseases	45

AIDS IN ARKANSAS
1985 - 1989

Total number of cases reported	252
Number of deaths	155

CASES BY SEX

Male	231
Female	21

CASES BY RACE

White	192
Black	58
Other	2

CASES BY RISK GROUP

Homosexual/Bisexual	164
Homosexual & IV Drug User	27
IV Drug User	27
Hemophiliac	2
Transfusion	12
Heterosexual (Contacts)	15
NIR#	5

No identified risk group (NIR)

CASES BY AGE GROUP

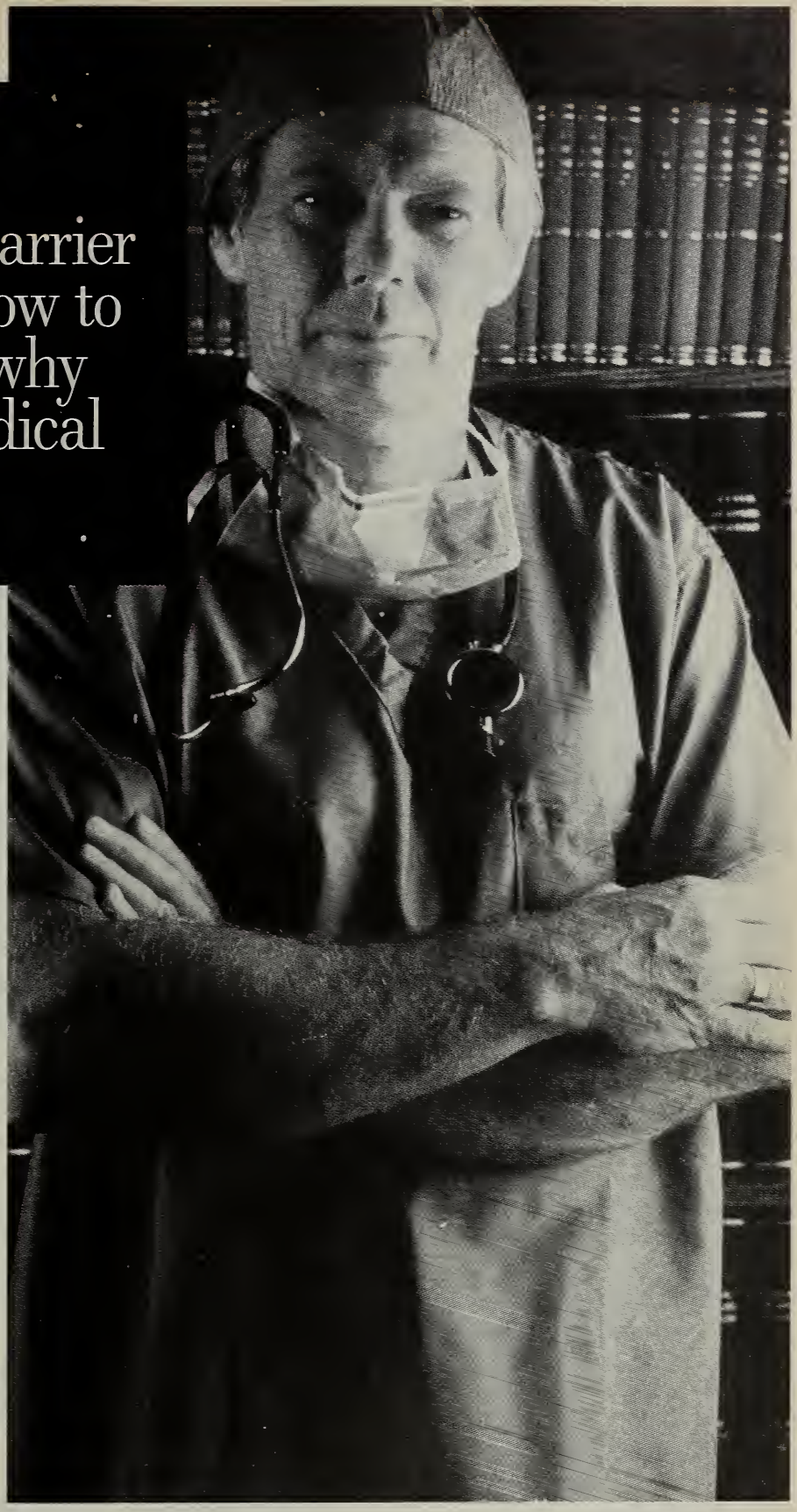
Less than 20	3
20 - 29	81
30 - 39	115
40 - 49	33
50 - 59	12
60 or more	8

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	114
Kaposi's Sarcoma	11
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	121

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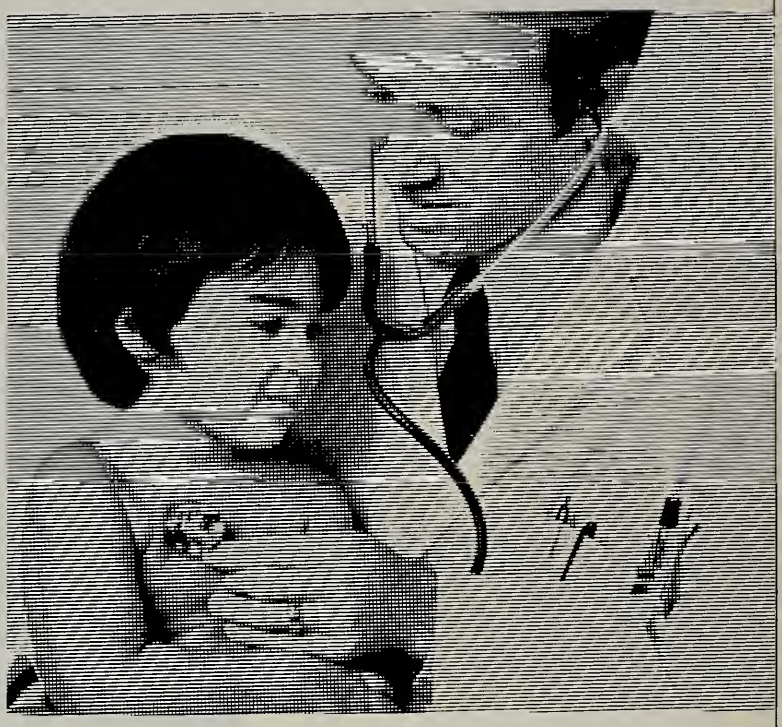
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The Management of Acute Organophosphate Poisoning

H. F. Simmons, M.D., Ph.D., R. E. Harrell, Jr., M.D., and C. Mason, M.D.*

The organophosphates are the most popular insecticides in use in the United States today due to low cost and rapid post-application decay. Over 100 are in use at present. Accidental or intentional exposure to them accounts for 80% of all serious insecticide poisonings. They are readily absorbed during gastrointestinal, dermal, inhalation, and conjunctival exposures. Many of them are toxic only after metabolic activation explaining the delay in symptom onset of up to 12 to 24 hours that is occasionally noted. In general, symptoms appear most rapidly after inhalation exposure and most slowly with dermal contact although a skin lesion may accelerate dermal absorption. Consequently, the latent period is a function of the particular agent involved, administration route and dose. A list of common organophosphate pesticides is included (see Table 1).

These compounds act by covalently binding to various cholinesterases, rendering them inactive, and secondarily producing excess acetylcholine accumulation in the central nervous system, ganglia, and neuroeffector junctions. If the bond is not broken by spontaneous hydrolysis or therapeutic agents, the enzyme is destroyed through additional changes within minutes to days depending on the compound. Interestingly, several "nerve" gases are actually organophosphates that produce enzyme destruction by this same aging mechanism within seconds after exposure. It is noteworthy that carbamates, another widely used category of insecticides, transiently inhibit cholinesterases producing a syndrome that is, aside from briefer duration, strikingly similar to that induced by the organophosphates.

As enzyme activity declines three principle sets of anticholinesterase induced signs and symptoms appear which correspond to initial stimulation and subsequent paralysis of transmission in muscarinic, nicotinic, and central nervous system synapses. Since peripheral muscarinic receptors are located in the parasympathetic postganglionic areas as well as in the sweat glands, signs of parasympathetic overdrive emerge in addition to diaphoresis. These include meiosis, salivation, bronchorrhea, bronchospasm, urination, defecation, cramping, and bradycardia. Nicotinic signs may develop as the autonomic ganglia and neuromuscular end plates are stimulated which include hypertension, tachycardia, pallor, fasciculations, weakness, and areflexia. Note that ganglionic stimulation augments both parasympathetic and sympathetic activities which are in opposition. Therefore, whether bradycardia or tachycardia appears, for example, is dependent on which type of tone predominates. Central nervous system malfunction manifests as restlessness, emotional lability, tremor, seizures, and depressed sensorium ranging from drowsiness to coma. Additionally, there is direct suppression of the central cardiovascular and respiratory drive centers. The constellation of signs and symptoms above constitutes the cholinergic toxic syndrome.

Organophosphate toxicity and in fact poisoning in general represents trauma at a cellular level. Like their macroscopic counterparts, toxicant induced biochemical lesions are often rapid in onset and slow in recovery, may occur at any age, and necessitate prompt therapy if optimal outcome is to be obtained. Additionally, the identify of the offending agent(s) may not be obvious as exemplified by a partial differential diagnosis for organophosphate toxicity which includes gastroenteritis, asthma, venomous arthropod bites, progressive peripheral neuropathy, nicotine poisoning, carbamate intoxication, meningitis, encephalitis, and Reyes Syndrome.

When confronted by a severely compromised patient in the absence of reliable history, a modified advanced trauma life support/advanced cardiac life support approach is prudent initially. These techniques are appropriate not only for the severely intoxicated individual, but also for the patient whose problems may only appear to be poison related. The airway, breathing, and circulatory status must be rapidly assessed and deficits corrected upon recognition. Gross level of consciousness should be determined and glucose, thiamine and naloxone administered when appropriate. The body surfaces should be rapidly inspected to identify any clues to toxicity. It is best to obtain blood for

*All three are doctors with the University of Arkansas for Medical Sciences, Little Rock, AR.

Table I. Commonly Used Organophosphate Insecticides
Modified from Tafuri and Roberts

Highly Toxic	Moderately Toxic
Tetraethyl pyrrophosphate	Bromophos-ethyl (Nexagan)
Phorate (Thimet)	Leptophos (Phosvel)
Disulfoton (Di-Syston)	Dichlorvos (DDVP, Vapona)
Fensulfothion (Dasanit)	Coumaphos (Co-Ral)
Demeton (Systox)	Ethoprop (Mocap)
Terbuphos (Counter)	Quinalphos (Bayrusil)
Mevinophos (Phosdrin)	Triazophos (Hostathion)
Methidathion (Supracide)	Demeton-methyl
Chlormephos (Dotan)	Propetamphos (Safrotin)
Sulfotepp (Bladafum)	Chlorpyrifos (Lorsban)
Chlorthiophos (Celathion)	Sulprofos (Bolstar)
Monocrotophos (Azodrin)	Dioxanthion (Delnav)
Fonophos (Dyfonate)	Isoxanthion (Karphos)
Prothoate (Fac)	Phosalone (Zolone)
Fenamiphos (Nemacur)	Thiometon (Ekatin)
Phosfolan (Cyolane)	Heptenophos (Hostaquick)
Methyl parathion (Dalf)	Crotoxyphos (Ciodrin)
Schraden (OMPA)	Cythioate (Proban)
Chlorfenvinphos (Birlane)	Phencapton (G28029)
Ethyl parathion (Parathion)	DEF (De-Green)
Azinphos-methyl (Guthion)	Ethion
Phosphamidon (Dimecron)	Dimethoate (Cygon, De-Fend)
Methamidophos (Monitor)	Fenthion (Baytex)
Dicrotophos (Bidrin)	Dichlorphenthion (Mobilawn)
Isophenphos (Amaze, Oftanol)	EPBP (S-Seven)
Bomyl (Swat)	Diazanon (Spectacide)
Carbophenothion (Trithion)	Phosmet (Prolate)
EPN	Formothion (Anthio)
Famphur (Warbex, Bo-Ana)	Profenfos (Curacron)
Fenophosphon (Agritox)	Naled (Dibron)
Dialifor (Torak)	Phenthoate
Cyanophenphos (Surecide)	Malathion (Cythion)

CBC, electrolytes, glucose, toxicology screen, liver and renal function plus extra tubes at the time intravenous access is secured.

With vital signs restored a less urgent history and secondary survey can be pursued. The most commonly encountered patient is suicidal. Other frequent presentations include residents of agricultural communities such as a dermally exposed child who has been playing in a freshly sprayed field or a pesticide applicator who began feeling bad several hours after beginning work. Frequently, a strong garlic-like odor is present that may suggest the diagnosis particularly if it occurs along with typical cholinergic findings. Rarely, an individual may inject the insecticide and lack the characteristic odor. Like any syndrome, that attributed to cholinesterase impairment will vary in completeness and in severity. For example, although 90% of the organophosphate poisoning victims will have pinpoint pupils, 10% will not. If the syndrome is identified, therapy with atropine and pralidoxime should be promptly initiated as detailed below. Organophosphate toxicity is unusual in that both physiologic and specific antidotes exist.

In any case, the next step is elimination of unabsorbed agent(s). Throughout this process, the staff must protect themselves from cutaneous and inhalational exposure. Gloves should be worn and the patient's clothing sealed in a container if grossly contaminated. The dermally exposed individual should be thoroughly cleaned with soap and water including the hair and nail beds. Some authors also recommend scrubbing the skin with an aqueous ethanol solution as well. Irrigation of the conjunctivae with copious amounts of water should not be neglected when appropriate. If the patient is alert and has a gag reflex, unprotected lavage or Syrup of Ipecac may be used to empty the stomach even if a hydrocarbon vehicle was concomitantly ingested. The ipecac should be followed by one gram per kilogram of activated charcoal and an appropriate dose of cathartic. If there is any question of potential airway compromise, the patient must be endotracheally intubated and lavaged through a large bore tube. One should not facilitate intubation with succinylcholine as it may aggravate the cholinergic syndrome. Rapid decontamination is desirable as there is no means of either neutralizing or removing the insecticide once

absorbed.

Laboratory data may be useful both to confirm diagnostic suspicions and to estimate the severity of the intoxication. The extra blood mentioned above should be sent for both red cell cholinesterase and serum pseudocholinesterase levels. The red cell cholinesterase is like that found in the synapses and theoretically is a better indicator of neural transmission capacity. However, pseudocholinesterase activity measurement is easier to perform and much more widely available. It should be recalled that 3% of the population lack this enzyme on a genetic basis and that it is often deficient in extensive liver disease. Normally cholinesterase activity largely rules out significant organophosphate exposure. In mild toxicity one sees 50% to 80% suppression with 80% to 90% in moderate poisoning and greater than 90% in severe cases. Goldfrank states that there are no reliable normal cholinesterase levels in children.

Two drugs are specifically indicated for these patients, Atropine and Pralidoxime. The first, Atropine, should be administered as soon as the cholinergic syndrome is recognized without awaiting the return of laboratory data. The adult dose is two to four milligrams intravenously every 15 minutes and the pediatric dose is 0.05 milligrams/kg at the same rate. The therapy is continued until the patient is ''atropinized'', which must include a significant clearing of the usually excessive tracheobronchial secretions. Pupillary dilation alone is not an adequate end point. It should be recalled that the most common cause of treatment failure is inadequate use of Atropine. The average patient will require 40 milligrams but amounts in excess of 1,000 milligrams have been used. Atropine is a physiologic muscarinic antagonist. Additionally, it will readily cross the blood brain barrier and reverse central manifestations of poisoning. There is no effect at nicotinic sites, however, and muscle twitching will be unaffected. Atropine therapy may be necessary for more than 24 hours and it should be reinstituted at the first appearance of recurrent muscarinic signs. (Carbamate intoxication should be managed with Atropine alone.)

The second drug, Pralidoxime, or 2-PAM, is marketed as Protopam. It is one of the few agents that truly repairs a biochemical lesion. This repair consists of actual displacement of the covalently bound organophosphate from the cholinesterase with immediate resumption of activity. Furthermore, it may inactivate circulating unbound insecticide and may have some endogenous anticholinergic properties. The drug should be given as soon as the patient has been stabilized with Atropine but after blood has been drawn for cholinesterase activity. (Pralidoxime causes the levels to lose their diagnostic significance.) Adults should receive one to two grams and children 25-50 milligrams per kilogram intravenously in 150 milliliters of normal saline infused over 30 minutes. Prompt therapy is important as once the enzyme-inhibitor complex ages, pralidoxime is ineffective. However, it is worthwhile if given within 24 to 48 hours after exposure. Victims of poisoning from fenthion, a highly lipophilic agent may still benefit from therapy weeks after exposure. Pralidoxime will ameliorate central, muscarinic, and nicotinic signs. In fact, muscle function often improves 10 to 40 minutes after injection. If fasiculations recur, the initial dosage may be repeated in one to two hours or an infusion can be started at 0.5 gram per hour as a 2.5 percent solution in saline.

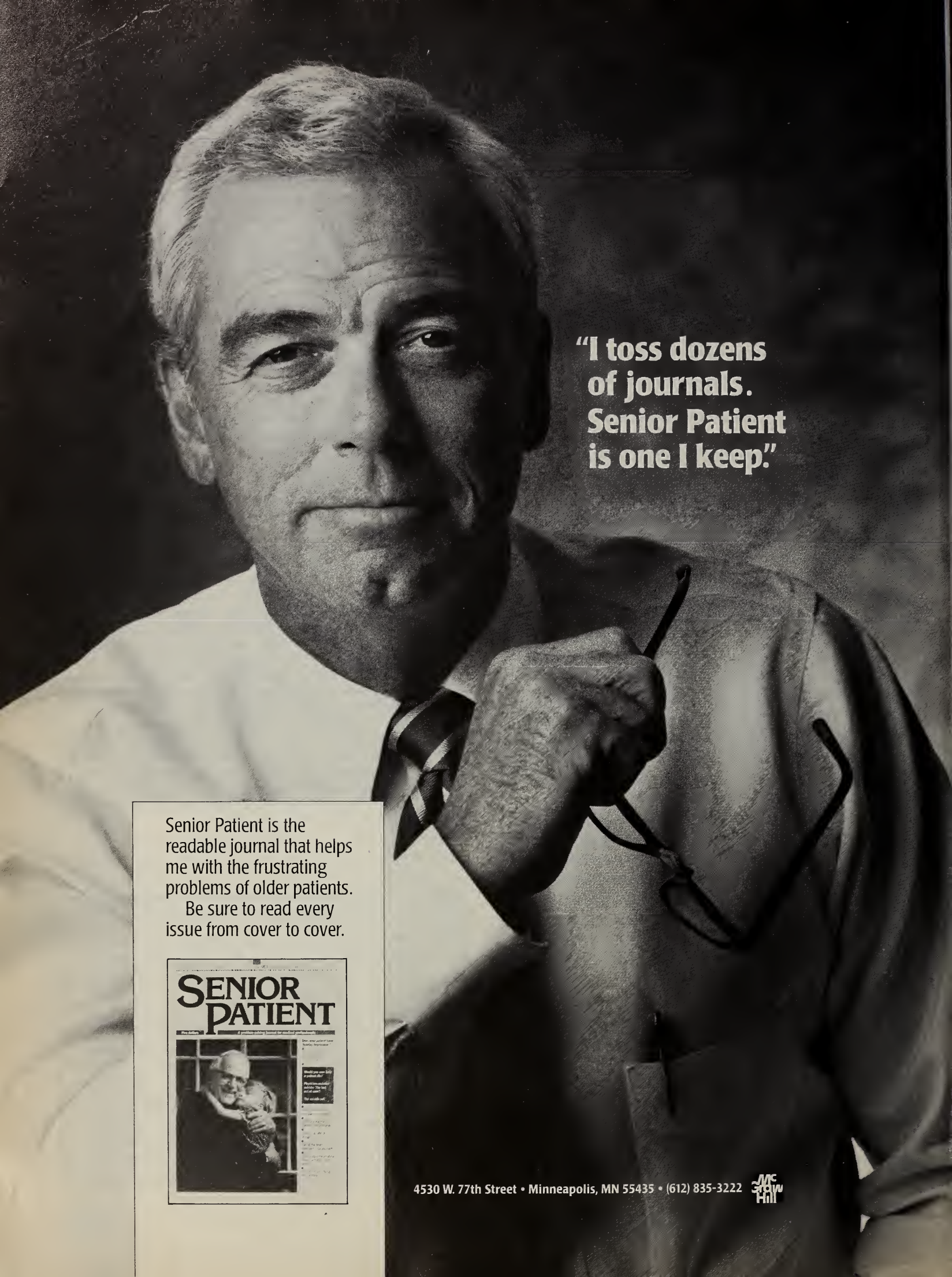
In summary, organophosphate intoxication produces an acute cholinergic syndrome that is often evident on physical examination. As soon as adequate vital signs have been restored, therapy with atropine and pralidoxime is initiated along with decontamination and good supportive care. If acute hypoxic CNS injury is avoided and prompt therapy instituted, recovery is usually complete within 10 days although delayed neurologic sequelae may appear. When death does occur, it is usually secondary to a combination of central cardiopulmonary depression, bronchorrhea, and bronchospasm.

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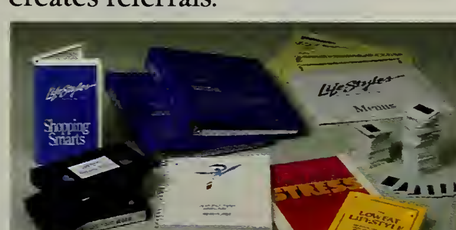
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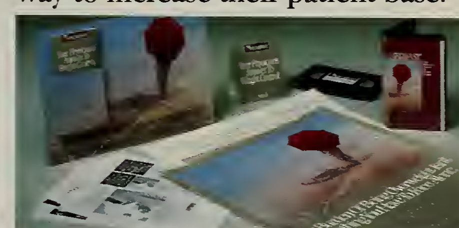
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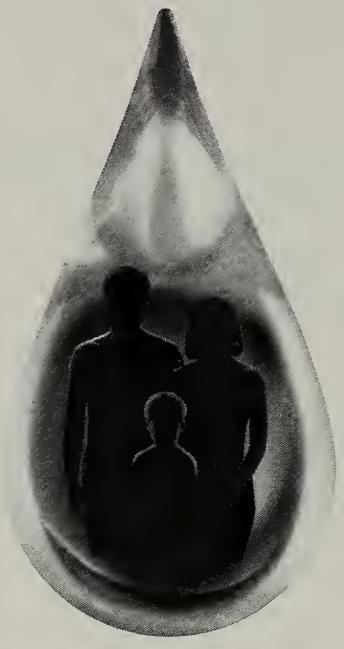
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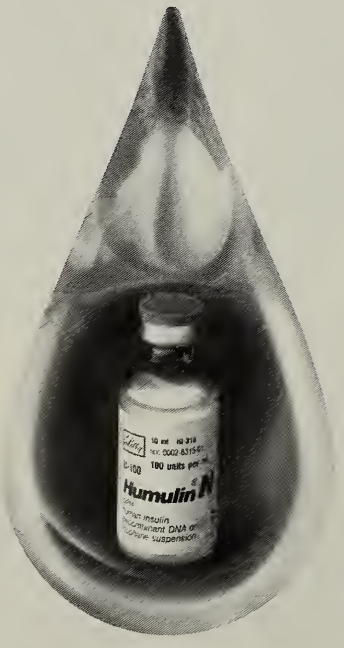
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Loss Prevention Case Study

A Monument To Failure

J. Kelley Avery, M.D.**

Case Presentation

A 60 year-old male, who six years earlier had had a diagnosis made of diverticulitis, had been asymptomatic for five years. He had been active and healthy until the present illness began three days earlier. On admission, he complained of increasingly severe cramping abdominal pain. On two occasions during the past few months, he had noticed a small amount of bright blood following bowel movements. He attributed the blood to "hemorrhoids" and did not consult his physician. Since the cramping abdominal pain began, he had not had a bowel movement.

On physical examination, the patient was found to have some generalized abdominal tenderness. The bowel sounds were "normal to hyperactive." A plain film of the abdomen revealed slight gaseous distention of the colon. A barium enema was ordered and, after multiple attempts, the colon was thought to be clean enough for a satisfactory barium study.

It was about 4:00 p.m. Thursday when the barium enema was begun. A technician was administering the barium when the patient complained of a brief episode of severe abdominal pain. The enema and fluoroscopy continued, and multiple films were made. On expelling the enema, some bright bleeding occurred which was reported to the technician.

The radiologist dictated the findings late in the day. The following day the report, which showed a "constricting lesion in the mid sigmoid," was transcribed. The report added that "a small amount of barium is seen outside the lumen of the bowel." Neither the pain during the enema nor the bleeding which followed were made a part of the report. The report was delivered to the patient's chart at 3:00 p.m. on Friday.

The surgeon went to the x-ray department after finishing in the operating room and before he made rounds on Friday evening. He looked at his patient's films and agreed with the diagnosis of a lesion in the sigmoid colon. He either did not see or did not recognize the extravasation of barium.

The patient developed some fever early on Saturday morning. He developed leucocytosis, increasing abdominal distention, and pain with generalized tenderness. Suspecting a ruptured bowel, full antibiotic coverage was ordered at that time. No bowel sounds could be heard. By mid-day on Saturday the patient had fever of 103. He had been NPO and had had nasal gastric suction since admission. All findings suggested a diagnosis of peritonitis secondary to perforation of the bowel. Monday a.m. a CT of the abdomen revealed fluid accumulation in the peritoneal cavity. Despite the compromised condition of the patient, surgery was done consisting of a left colectomy and colostomy. The surgeon felt that "due to peritonitis" time should not be taken to re-establish continuity of the bowel. There was extreme peritoneal contamination with purulent material in the pelvic area. Multiple drains were used in an attempt to provide drainage and prevent further abscess formation.

The patient's condition rapidly deteriorated. Fever continued. Two additional attempts were made to drain the peritoneal abscesses. Sepsis was present and even with culture specific antibiotics, the patient died on the fifth post-op day.

Six months later the surgeon, the radiologist, the x-ray technician and the hospital were sued. Ultimately, a large settlement was required. All the defendants contributed equally to the settlement.

Case Discussion

The x-ray technician who knew of the severe pain during the administration of the barium enema and the bleeding that followed made no written report.

The radiologist who saw the extravasation of barium made no special effort to inform the surgeon even though this is a true medical and surgical emergency.

The surgeon read the films himself, but did not see the extravasation which ultimately killed the patient. Although the surgeon had done a good job of securing and documenting informed consent, he was not attentive to the spouse who after the initial grief of her husband's death became very angry at all concerned. When she learned of the perforation of the colon, the delayed x-ray report, etc., she filed her lawsuit.

Case Resolution

The hospital was charged with negligence in the delay of getting the report of the radiologist transcribed and on the chart.

Every error made in the care of this patient was critical to his treatment. All the errors converged on our patient and his death became a monument to our failure.

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**Dr. Avery is Chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood, TN, and Medical Director Ambulatory/Outpatient Services, St. Thomas Hospital, Nashville, TN.

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Nuclear Cardiac Imaging

J. Douglas Holloway, M.D.*

During the last 15 years, nuclear methods have assumed an increasingly important role in the evaluation of cardiovascular disorders. Following intravenous administration of radiolabeled agents, computer-processed gamma camera images provide unique information regarding myocardial perfusion and ventricular function. This non-invasively acquired physiologic data complements, and in some cases, obviates the need for anatomic depiction by cardiac catheterization.

This article will review the three major nuclear cardiac studies:

(1) Myocardial perfusion imaging using the thallium stress test
(2) Radionuclide ventriculography
(3) Myocardial infarction imaging

Additionally, comments regarding future imaging techniques will be provided.

THALLIUM PERFUSION IMAGING

After its original development in the late 1960s, the treadmill stress test was rapidly accepted as a diagnostic screen for coronary heart disease. Enthusiasm for stress electrocardiography was soon tempered by the recognition of significant false positive and false negative rates, approaching 20% and 40%, respectively (1). Therefore, a more sensitive and specific method of assessing myocardial blood flow was sought. After less successful initial efforts with potassium and rubidium isotopes (2), thallium 201 emerged as the optimal cardiac perfusion radionuclide. Thallium 201 is a relatively long-lived agent (half life = 73 hours), which is extracted by cardiac (and skeletal) muscle following intravenous administration. When injected at peak exercise myocardial uptake of thallium 201 is rapid and efficient.

Typically, 2-4 millicuries of thallium 201 is injected 60-90 seconds before termination of exercise, with gamma camera cardiac imaging immediately post-exercise and 3-4 hours later. In the event of exercise-induced ischemia, initial myocardial perfusion defects will demonstrate (with some exceptions) reaccumulation of the nuclide on delayed images. Scar tissue at the site of myocardial infarction will demonstrate no such isotope redistribution on delayed images. Properly performed thallium studies can diagnose coronary artery disease with a sensitivity and specificity of 85-90%, particularly when quantitative computer analysis is applied, (3).

Because of the added cost of isotope and imaging, thallium stress evaluation is not generally an appropriate initial test for routine clinical purposes. However, since it does not rely on the exercise ECG to assess perfusion, thallium stress is invaluable for the patient with a nondiagnostic or inconclusive stress test (4). Common examples include women, patients on digitalis or thiazide diuretics, or those with left ventricular hypertrophy or left bundle branch block, all of which are often associated with false positive or uninterpretable exercise electrocardiographic changes.

Of the 750-800,000 thallium stress tests performed annually in the U.S., most are for diagnostic purposes. Another important use of thallium imaging is to assess the functional significance of know coronary disease. For example, coronary restenosis following angioplasty can yield significant diagnostic and prognostic information in the early post-infarction setting, of particular importance in this era of thrombolytic therapy (6,7).

Noninvasive evaluation of coronary artery disease is traditionally difficult in patients with physical debilities which preclude treadmill testing. Therefore, the dipyridamole thallium stress test was devised. In this study, dipyridamole (a potent coronary vasodilator at high doses) is administered and combined with initial and delayed thallium imaging. Such pharmacologic stress studies have found particular utility in preoperative cardiac risk assessment of the patient with peripheral vascular disease and disabling claudication (8). While oral dipyridamole studies are currently available at university centers, private imaging centers, and large community hospitals, intravenous dipyridamole awaits FDA approval.

Tomographic (SPECT) imaging represents a recent development in which computer constructed myocardial "slices" are produced following acquisition with a gamma camera which rotates in an arc around the supine patient. Tomographic analysis helps eliminate tissue overlap and can be slightly more sensitive at detecting segmental perfusion defects compared with the standard "planar" technique. However, its increased complexity yields more false positive studies, rendering tomographic imaging a somewhat less specific method for coronary artery disease diagnosis.

*Arkansas Cardiology Clinic, P.A., Medical Towers II, Suite 600, 9501 Lile Drive, Little Rock, Arkansas 72205.

RADIONUCLIDE VENTRICULOGRAPHY (RNV)

Developed in the early 1970s, this technique allows for quantitative evaluation of segmental and global ventricular function. Typically, 3-5 cc's of the patient's blood is labeled with 25-30 mCi of technetium as Tc99m (half life = 6 hours) following chemical erythrocyte preparation with pyrophosphate injected intravenously. Gamma camera image acquisition in multiple views is next performed. Synchronizing acquisition of the cardiac cycle via ECG, and subsequent computer processing yield endless loop "movies" of ventricular systolic and diastolic function, as inferred from cardiac blood pool motion. Alternatively, Tc99m can be injected in bolus form with rapid data acquisition over several cardiac cycles ("first pass" imaging). First pass and the aforementioned equilibrium techniques each have inherent advantages and disadvantages.

Because left ventricular function is such a vital cardiac prognostic factor (9), RNV has become a valuable tool for the clinician, comparing favorably with contrast ventriculography. Analysis of ventricular function is useful in the unstable angina or post-infarction setting (10), to follow the patient receiving Adriamycin (11), or to differentiate systolic from diastolic dysfunction as cause of congestive heart failure (12).

"With the development of exciting future techniques, the utility of nuclear imaging in cardiovascular medicine will expand further."

When rest images are combined with stress images (usually bicycle exercise to minimize thorax motion), RNV evaluates the effect of exercise on ventricular function. These rest-stress studies are helpful in diagnosing obstructive coronary artery disease (segmental or global drop in ejection fraction with exercise-induced ischemia) or defining proper timing for valve replacement surgery (13, 14). Apart from assessing left ventricular and right function, RNV may contribute to the assessment of valvular regurgitation, ventricular aneurysm, and intracardiac shunt flow (15).

Quantification of left ventricular function via RNV is precise and reproducible, while accurate right ventricular analysis is often difficult. By comparison, 2D and Doppler echocardiography allow for a less quantitative estimation of ejection fraction but provide far more information regarding valve dysfunction and congenital cardiac disorders than does RNV.

MYOCARDIAL INFARCTION IMAGING

When injected during the first 48-96 hours after myocardial infarction, technetium pyrophosphate accumulates within the region of fresh necrosis. With subsequent planar or tomographic gamma camera image acquisition, infarcted myocardium may appear as a "hot spot" (16).

This technique is limited by relatively low sensitivity and specificity rates, particularly with small non-transmural infarctions. It is occasionally, however, the only method available to define recent infarction. One such example is a patient with baseline left bundle branch block who presents 2-3 days after symptoms of severe chest pain - when cardiac enzymes have returned to baseline. Beyond 4-5 days from an infarction, pyrophosphatase uptake by necrotic myocardium is limited.

FUTURE TECHNIQUES

Thallium 201 is a cyclotron-produced nuclide requiring costly shipping from one of a handful of centers around the country. Because of this and some technical physical imaging disadvantages with thallium, great interest currently exists for a class of agents known as the "isonitriles". These Tc99m labeled pharmaceutical products generate crisp myocardial images. Following their FDA approval in the near future, these agents will assume an important, though probably not exclusive, role in perfusion imaging.

Positron Emission Tomography (PET) utilizes very short-lived isotopes and a special camera to assess organ functions, including perfusion and metabolism. When combined with physical or pharmacologic stress, cardiac PET can diagnose obstructive and non-obstructive coronary artery disease with sensitivity rates approaching 100%. In addition, PET can offer unique information about myocardial viability by assessing glucose and fatty acid metabolism (17). Such data, unavailable through any other diagnostic method, can be critical for making proper judgements about revascularization procedures. Currently, the extreme cost of PET imaging centers and the limited availability of these special isotopes make PET imaging impractical for the community hospital.

New radionuclide techniques are being developed for a variety of physiological purposes, including infarction and myocarditis imaging (18), fatty acid metabolism (19), and cardiac adrenergic nerve activity (20).

Finally, a non-imaging nuclear probe "vest", linked to an ambulatory ECG recorder allows for accurate assessment of moment-to-moment ejection fraction changes (21). This recently introduced device, when more widely available, is expected to offer unique data regarding the hemodynamic consequences of arrhythmias and intermittent ischemia, both symptomatic and silent.

CONCLUSION

Thus, nuclear imaging has emerged as an essential diagnostic option for evaluation of the cardiac patient. Complementing the anatomic definition provided by cardiac catheterization, these widely available non-invasive methods allow for safe and accurate assessment of myocardial perfusion and ventricular function. With the development of exciting future techniques, the utility of nuclear imaging in cardiovascular medicine will expand further.

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Professional help for health professionals.

Substance abuse is a growing problem among health professionals. At Timberlawn Psychiatric Hospital, a special program exists to help health professionals overcome substance abuse problems.

A range of treatment options, individual and group therapy programs, and other recovery-oriented services are all geared toward the unique needs of the health professional. An individualized evaluation leads to selection of the most appropriate treatment program, which is further enhanced by specialized aftercare and monitoring services. Treatment team members include Board Certified psychiatrists, clinical psychologists, psychiatric social workers and substance abuse counselor specialists with certification in their field.

At Timberlawn, we understand the unique challenges faced by health professionals today, and we're here to help. For more details on our facility or referral arrangements, contact: Dr. Edgar P. Nace, Chief of Substance Abuse Services.

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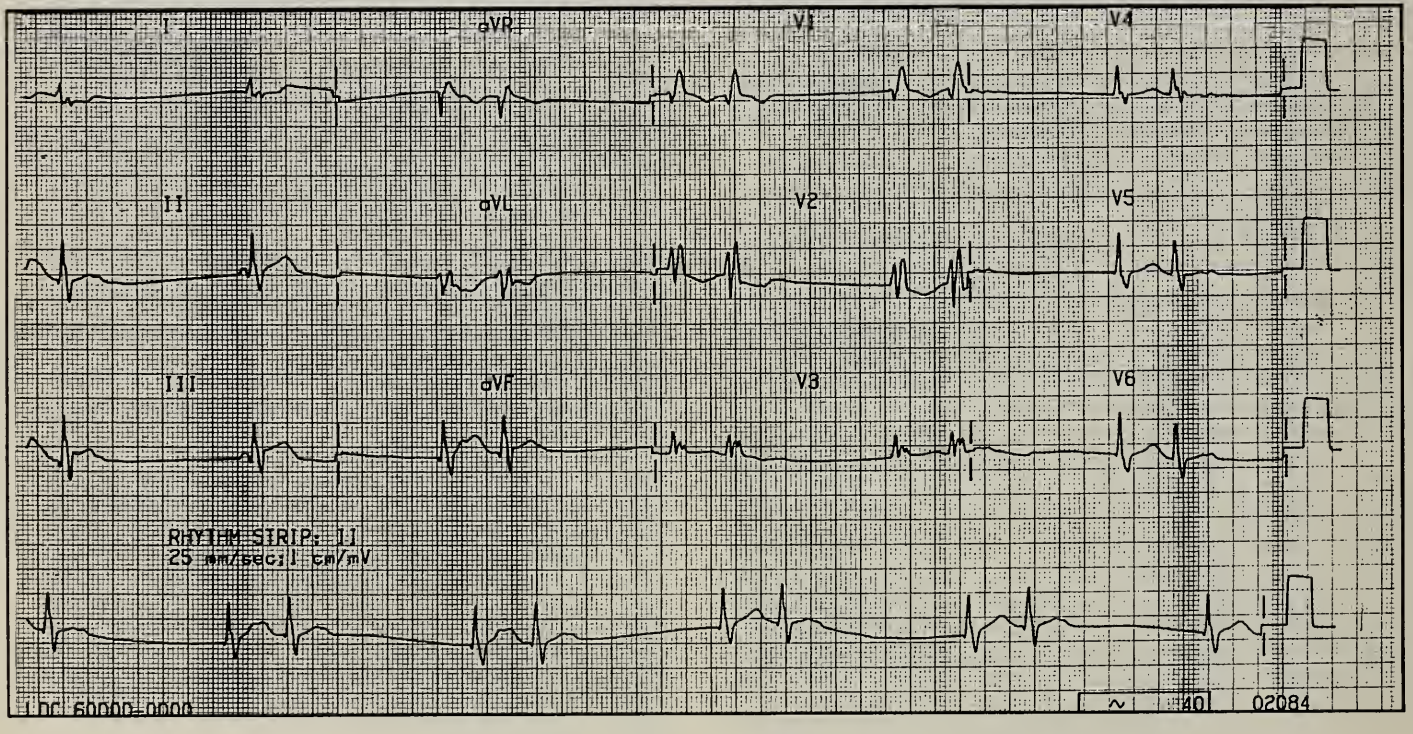


ELECTROCARDIOGRAM of the MONTH

William C. Roberts, M.D.
John W. Watson, M.D.
Division of Cardiology
UAMS, Little Rock, Arkansas

CLINICAL HISTORY:

M.N. is a 70-year-old man who presented to the hospital because of syncope. The physical examination revealed a normotensive patient with a slow regular rhythm and a grade two of six systolic ejection murmur but with no crackles in the lungs nor gallop sounds. What do you think of his electrocardiogram?



DISCUSSION:

The only antegrade P-wave on the trace is noted in association with the second QRS complex. The PR interval for the second complex is 0.08 seconds, so the P-wave may not be conducted. Several complexes suggest retrograde conduction of P-waves. With the third complex, bigeminal rhythm is present but with no discernable antegrade P-waves. Right bundle branch block pattern is present throughout the trace. Thus, the patient appears to have a junctional mechanism with bigeminy in RBBB pattern. One cannot exclude a 3:2 Wenckebach-like phenomenon below junctional level.

The feature editor wishes to thank Dr. Roberts of Conway, Arkansas, for his contribution to this month's electrocardiogram.

Physician Advisors



J. David Busby, M.D., ABFP, ABQAURP*

The philosophy of the Board of Directors of the Arkansas Foundation for Medical Care, Inc. regarding physician reviews is documented by the bylaws which state, "The Board of Directors shall devise and cause to be implemented a plan, for continuously recruiting eligible physicians as members and reviewers." It is the desire of the Board that qualified physicians be selected, trained and retained as physician reviewers. Physician reviewers for the AFMC are known as Physician Advisors.

Physician Advisors must be members of the AFMC. Membership is open to all licensed physicians in Arkansas who are in active practice.

When physicians apply to become Physician Advisors for the AFMC, a standard application form is completed. Upon completion of the application, the AFMC obtains the profile of the physician from the Data Department of the AFMC. This profile lists the number of Medicare admissions, the number of admissions denied, the number of DRGs changes, and the quality of care problems identified for a special period of time.

If the profile indicates that the applicant falls within the statewide averages for admission denials, DRG changes and quality of care problems , the application process proceeds.

Applicants are asked to sign an authorization allowing the AFMC to contact the hospitals where they have staff privileges to ascertain if they are in good standing. At the November 18, 1989 meeting of the Board of Directors of the AFMC, the Board required that the Arkansas State Medical Board also be contacted. The applicant is asked to sign a waiver so that information may be obtained from the Arkansas State Medical Board.

After the information has been obtained from hospitals and the Arkansas State Medical Board, a decision is made as to whether or not the individual can be appointed as a Physician Advisor. Beginning January 1, 1990, all new Physician Advisor applicants will be reviewed by the Credentials Committee of the AFMC. This committee is chaired by a member of the Executive Committee of the AFMC Board of Directors and includes other members of the Board of Directors and a member-at-large from the general membership of the AFMC. If the Credentials committee approves the appointment, the full Board is asked to endorse the appointment at the next regularly scheduled meeting.

After a new Physician Advisor has been credentialed, he/she must attend a Physician Advisor Training Seminar before they can perform review for the AFMC. This lengthy seminar covers the scope of activities of the AFMC. A Physician Advisor Manual (180+ page manual) is given out at that time. The new Physician Advisor is asked to read the Physician Advisor Manual within the next three weeks. At the end of the three-week period, a questionnaire is sent to the Physician Advisor to document whether or not the Physician Advisor has completed review of the manual and desires to do review for the AFMC, charts are sent for review.

The first 30 charts reviewed by a new Physician Advisor are evaluated by established Physician Advisors for the AFMC. Each case is re-reviewed and any mistakes are corrected. An educational critique is provided and the new Physician Advisor each time a set of charts is submitted.

If the Physician Advisor is performing satisfactorily after the first 30 charts, the Physician Advisor is moved to the list of established Physician Advisors.

Established Physician Advisors are monitored by the AFMC. The Data Department of the AFMC randomly selects 3% of the cases reviewed by the Physician Advisor each quarter. These cases are then evaluated to determine whether or not the Physician Advisor is performing at an acceptable level. At the end of a year, the Physician Advisor will be provided an overall review of his performance. If problems are identified, the Physician Advisor is contacted by phone or by letter. If necessary, the AFMC can remove a Physician Advisor for the list of Physician Advisors.

Physician Advisors for the AFMC are reimbursed at the rate of $58.25 per hour. No time limits are imposed on Physician Advisors, although experienced Physician Advisors can review three to five records per hour. Records involving quality of care questions take longer than this.

If you are interested in becoming a Physician Advisor, please contact the Arkansas Foundation for Medical Care, Inc. in Fort Smith, Arkansas.

*Executive Vice President for Medical Affairs, AFMC, Inc., 809 Garrison Avenue, Fort Smith, Arkansas 72902-2424

Things To Come

February 22-25

8th Annual Internal Symposium on Man and His Environment in Health and Disease. Presented by an international faculty from England, Belgium, Japan, Canada, China and the United States. Sponsored by The American Environmental Health Foundation and the American Academy of Environmental Medicine. The Grand Kempinski Hotel, Dallas, TX. Twenty-four and one half Category I credit hours. Fees: $345, Physicians; $10/day, students, resident, interns and Fellows; $295 all other health professionals.

February 22-24

The New Orleans AIDS Conference: Management of HIV Disease for the Primary Care Physician. Presented by Robert Redfield, M.D., Walter Reed Hospital; Michael Hickey, M.D., San Francisco; Michael Polis, M.D., National Institutes of Health; and Ronald Grossman, M.D., New York. Sponsored by the Louisiana State University Medical School and the AIDS Education and Training Center. New Orleans Hyatt Regency Hotel, New Orleans, LA. Fee: $210 before January 25 and $225 after January 25. For further information contact Mr. Bart Reilly, AIDS Education and Training Center,(504) 568-3855.

February 25 - March 1

21st Family Medicine Review - Session I. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson, University of Kentucky, (606) 233-5161.

March 4-9

17th Annual Critical Care Medicine Course. Presented and sponsored by the University of Oklahoma Health Sciences Center. Holiday Inn Airport West, Oklahoma City, OK. CME credit available. Fee: $600 includes all workshops, five breakfast buffets and luncheons. For further information, call D. Robert McCaffree, M.D. or Dora Lee Smith at (405) 271-5904.

March 24-29

Spring Meeting of the American Society of Clinical Pathologists. Presented and sponsored by ASCP/CAP. San Francisco Civic Auditorium, San Francisco, CA. CME credit available. For further information, call ASCP at 1 (800) 621-4142.

March 30-31

Contemporary Pediatrics for the Practicing Physicians. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact the Susan Gilson, University of Kentucky, (606) 233-5161.

March 30 - April 1

Pediatrics 1990. Presented by Elizabeth R. McAnarney, M.D. (Adolescence); Raymond V. Caputo, M.D., (Dermatology); Sarah S. Long, M.D. (Infectious Diseases); Avroy A. Fanaroff, M.D. (Neonatology); Michael J. Goldberg, M.D. (Sports Medicine). Sponsored by the American Academy of Pediatrics. Marco Island Hilton Hotel, Marco Island, FL. Sixteen Category I credit hours. Fees: $220, AAP Resident Fellow, Candidate Fellow and allied health professionals; $300, AAP Fellow; $365, nonmember physician. Further information call 1 (800) 433-9016 and ask for CME Registration.

April 5-6

17th Annual Symposium on Obstetrics and Gynecology. Presented and sponsored by the Washington University School of Medicine. Washington University Medical Center, St. Louis, MO. CME credit available. For further information contact, Cathy Caruso, CME, Washington University School of Medicine, 1 (800) 325-9862.

April 6-7

Aggressive Management of Diabetes and Obesity. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson, University of Kentucky, (606) 233-5161.

April 18-22

10th Annual National Pediatric Infectious Disease Seminar and Special Session on A Preventive Approach to Medical Malpractice. Sponsored by the Department of Pediatrics, Southwestern Medical Center, Dallas, TX. Hyatt Regency Hotel, New Orleans, LA. Twenty-one Category I credit hours available for the Symposium and Seminar; 3 Category I credit hours for the Special Session. Fees: $350, physicians; $250, residents, Fellows, PA's and PNP's. For further information call (214) 688-8845.

April 27-28

Sports Medicine for Physicians. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson at (606) 233-5161.

May 2-5

Ambulatory Surgery '90: Focus on Excellence. Sponsored by the Federated Ambulatory Surgery Association. Anaheim Marriott. For further information, contact Gail Durant, (703) 836-8808.

May 19

Trauma Symposium. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington,KY. For further information contact Susan Gilson at (606) 233-5161.

May 20-26

21st Family Medicine Review - Session II. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson at (606) 233-5161.

May 25-27

Advances in Pediatrics. Presented by Catherine DeAngelis, M.D. (Ambulatory Pediatrics); Burton W. Fink, M.D. (Cardiology); Mark Sperling, M.D. (Endocrinology); Georges Peter, M.D. (Infectious Diseases); John E. Lewy, M.D. (Nephrology); Charles F. Weiss, M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Hilton Head Island, South Carolina. Sixteen Category I credit hours. Fees: $220, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016 and ask for CME Registration.

June 1-2

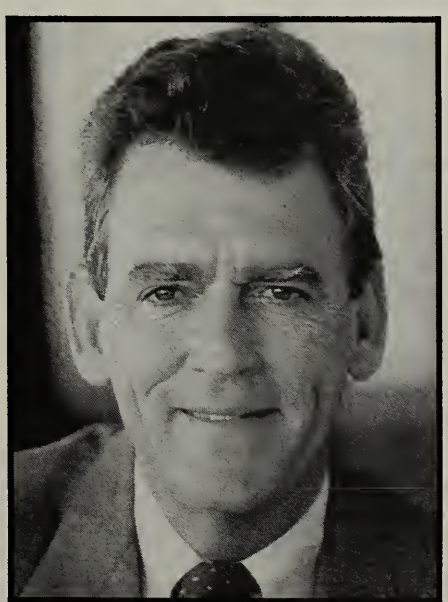
3rd Annual Contact Lens Course. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 7-9

Frontiers in Endosurgery: Flexible Endoscopy, Laser Surgery and Endourological Techniques. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. FOR UROLOGISTS ONLY. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 22-24

Clinical Pediatrics. Presented by Richard J. Summers, M.D. (Allergy); Barton D. Schmitt, M.D. (Behavioral Pediatrics); Sidney Hurwitz, M.D. (Dermatology); William F. Balistreri, M.D. (Gastroenterology); Ellen R. Wald, M.D. (Infectious Diseases); R. James McKay Jr., M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Washington, D.C. Fees: $200, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016.



Marcus Conant, M.D.
Keynote Speaker

AMS 3rd ANNUAL AIDS SEMINAR

Park Hilton Hotel, Hot Springs, Arkansas
Saturday, March 17, 1990
8:00 a.m. - 12:30 p.m.

Dr. Conant has had a lifelong interest in sexually transmitted diseases and devoted much of his time to the study of epidemiology and treatment of genital herpes.

In 1981, shortly after the onset of the AIDS epidemic, he established the first multidisciplinary clinic in the United States for evaluation and treatment of patients with Kaposi's Sarcoma. Dr. Conant also started the Kaposi's Sarcoma Foundation, which became the San Francisco AIDS Foundation.

In 1983, Dr. Conant obtained funds from the State of California to establish the AIDS Clinical Reasearch Center at the Universtiy of California Medical Center in San Francisco. He served as Director from 1983-1986. He was named Chairman of the California State Department of Health's AIDS Task Force in 1983 and Co-Chair of the California AIDS Leadership Committee in 1988.

KEEPING UP

Cardiology Update 1990

February 23, 7:30 a.m. - 4:00 p.m. Presented and sponsored by the Baptist Medical Center. J. A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. Six Category I credit hours. Fee: $75, physicians; $30, nurses, pharmacists and other allied health professionals.

12th Annual Seminar on Perinatal Medicine

March 1-4, times to be announced. Presented by Frank C. Miller, M.D. Sponsored by UAMS College of Medicine. Orlando, FL. Fees and CME credit to be announced.

Third Annual AIDS Seminar

March 17, times to be announced. Sponsored by the AMS Committee on AIDS. Hot Springs Hilton Hotel, Hot Springs. Program to include general session, concurrent sessions and luncheon speaker. CME credit pending.

25th Annual Surgical Symposium

March 23-24, times to be announced. Presented by Robert Barnes, M.D. Sponsored by UAMS College of Medicine. Hot Springs. Fees and CME credit hours to be announced.

The Hot Springs Regional Perinatal Conference

March 30-31, 7:30 a.m. - 11:50 a.m. Sponsored by the Arkansas High Risk Pregnancy Program and the University of Arkansas for Medical Sciences Department of Continuing Education for Physicians. Lake Hamilton Resort and Conference Centre, Hot Springs. Seven Category I credit hours. Fees: Physicians, $50; Nurses and other professionals, $35; Full-time students and residents, $20 ; Guests, $15.

Cardiovascular Conclave 1990

April 7, times to be announced. Presented by the Arkansas Cardiovascular Surgery Associates, P.A. Sponsored by Baptist Medical Center, Little Rock. University Conference Center, Little Rock. Five Category I credit hours. No Fee. For further information, contact Patricia Pollack, 224-5666.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Building Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Sturgis Auditorium

Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

CARTI Tumor Conference, first Wednesday, 12:00 noon, CARTI Auditorium. Lunch is served.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. Sandwich buffet served.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
General Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. Lunch is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Surgery Journal Club, Mondays, 12:00 noon, Operating Room Conference Room (2 Northwest). Sandwich buffet served.
Interdisciplinary AIDS Conferernce, second Friday, 12:00 noon, LaHarpe Room. Sandwich buffet is served.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Peripheral Vascular Disease, fourth Tuesday, 6:00 p.m., J. A. Gilbreath Conference Center, Room 8.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141

Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Rom G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
*Urology Morbidity and Mortality Conferenc*e, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

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Third Annual AIDS Seminar
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Sponsored by the AMS Committee on AIDS. Program to include general session, concurrent sessions and luncheon speaker. CME credit pending. Watch for further information.

Medicine in the News

MacArthur Foundation Continues Fight Against Parasitic Diseases

Continuing the fight against parasitic diseases is the goal of more that $5 million in grants announced by the John D. and Catherine T. MacArthur Foundation.

Grants totaling of $4 million in continued support will go to the Foundation's highly successful five-year-old Consortium on the Biology of Parasitic Diseases, consisting of eleven medical research groups in five states and three foreign nations. In addition, $1.1 million will support the new Network on the Biology of Parasite Vectors, consisting of five research institutions in the U.S. and Crete.

"Five years ago, the Foundation began a major commitment to discovering new means of controlling parasitic diseases such as malaria, tapeworm, dysentery, and African sleeping sickness," states Adele Simmons, MacArthur Foundation president. "Today, much has been accomplished, but much remains to be done."

Simmons states that "in addition to the terrible toll these diseases still take on the hundreds of millions of rural and urban poor in tropical developing countries, parasitic diseases such as Pneumocystis carinii are often the cause of death in victims of AIDS. Also, parasites such as the one that causes malaria are becoming resistant to current drugs. The Consortium on the Biology of Parasitic Diseases has been a catalyst in the field, and these new grants will continue the momentum this work has created."

"Funding for parasitic disease research continues to be woefully inadequate, at both the national and international levels," notes Denis J. Prager, director of th MacArthur Foundation's Health Program. "Continued support of the Program means that significant progress will continue to be made in understanding the biology of parasitic diseases."

In the United States, eight institutions will receive MacArthur funds as part of the Consortium on the Biology of Parasitic Diseases and four institutions will receive MacArthur funds as part of the Network on the Biology of Parasitic Vectors.

Levi Hospital Celebrates Their 75th Anniversary

Levi Hospital, located in Hot Springs, AR, conducted an "Open House" recently to celebrate their 75th Anniversary. Included in the open house was a 17 station tour, health screenings, historical exhibits, refreshments and a gift for all who attended.

Long been recognized as a leader in arthritis treatment, Levi Hospital has recently expanded the program base and areas of treatment in order to meet the growing needs for rehabilitation.

Each program that Levi Hospital offers was developed with the same attention to quality for which Levi is synonymous. Levi strives to bring increased awareness to these programs so that they will be able to touch more and more individuals. Levi will continue to look in the horizon for unmet needs and will move into these areas swiftly and with high quality.

Physician's Recognition Award

During the month of March, all of the physicians in the State of Arkansas who do not have valid certificates for the AMA Physician's Recognition Award will be mailed an application form. The form is sent as a service to physicians, both AMA members and non-members, who are interested in receiving recognition of their continuing medical education activities.

Northeast Arkansas - modern community hospital is looking for specialists in the following areas: a director of emergency medicine, ENT, urology, and internal medicine. Excellent financial opportunity offered under ideal practice conditions. Excellent family environment, outstanding school system, nearby recreational hunting opportunities. Please send resume to Suite 1, Arkansas Methodist Hospital, 900 W. Kings Highway, Paragould, AR 72450. Phone (501) 239-7100.

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AMS NewsMakers

Mark A. Enderle, chief of medical services at the Veterans Administration Medical Center in Fayetteville, recently received a three-year appointment as Cancer Liaison Physician for the cancer program at the VA. The program is an integral part of the Commission on Cancer of the American College of Surgeons.

Ray E. Stahl, M.D., FACS, of Mountain Home recently received a three-year appointment as cancer liaison physician for the cancer program at Baxter County Regional Hospital.

Dr. Stahl is among a national network of 2,300 volunteer liaison physicians who provided leadership and support to the Hospital Cancer Program and the Commission on Cancer activities.

Robert Elliott, M.D., of Searcy was recently elected vice president and professional education chairman of the board of directors of the Arkansas Division of the American Cancer Society.

The Arkansas Division board of directors is comprised of 67 members from around the state. They are responsible for overseeing the American Cancer Society's programs of fund raising, research, education and service in Arkansas.

The Arkansas Chapter of the American College of Physicians awarded **Dr. Arthur Haut**, professor of medicine at the University of Arkansas for Medical Sciences, recently with the Robert Shields Abernathy Award for Excellence in Internal Medicine. The award is given annually to an internist who has trained, practiced or taught in Arkansas and achieved distinction in the profession. Haut has been with UAMS since 1963.

Steve P. Schoettle, M.D., a West Memphis surgeon, is one of nine Arkansas surgeons recently initiated into the Fellowship if the American College of Surgeons.

Gene E. Tullis, M.D., a thoracic and cardiovascular surgeon in Jonesboro, has been selected as a Fellow of the American College of Surgeons, the largest organization of surgeons in the world.

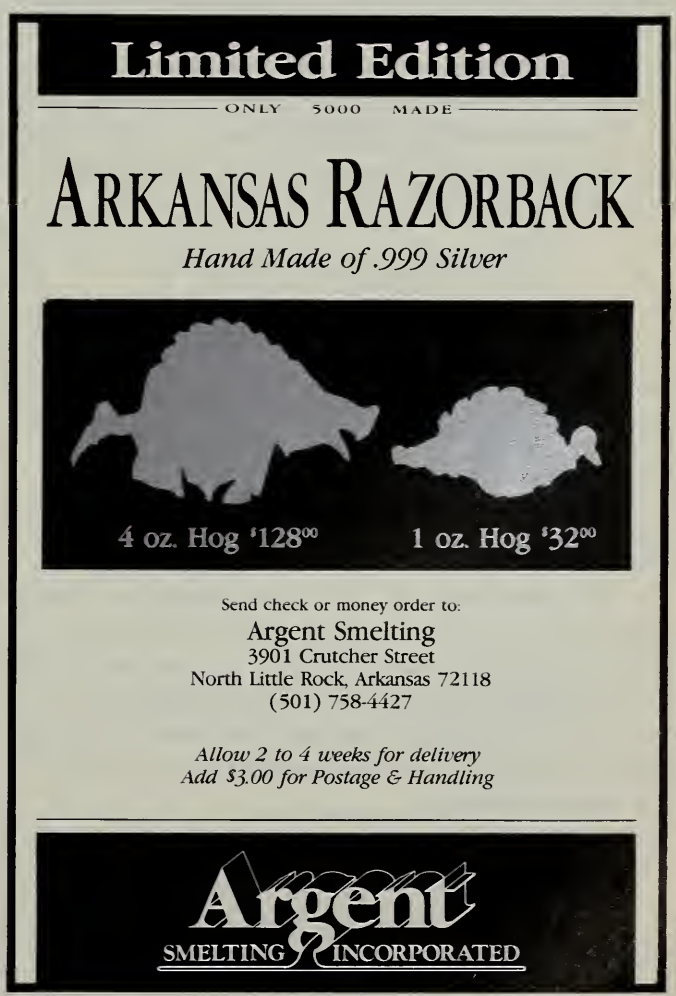
The Rich Mountain Manor marked 10 years of service by their medical director, **Dr. Calvin Austin**, recently with a surprise party given by the staff and residents of the manor.

William Dale Dedman, M.D., of Camden, has been recertified as a diplomat of the American Board of Family Practice (ABFP) by passing a recertification examination offered by the ABFP.

By passing the exam, he maintains a specialist status in the medical specialty of family practice, the first specialty to require diplomats to be recertified every six years.

David C. Jacks, M.D., a urologist from Pine Bluff, has recently been appointed the Southern Medical Association's Councilor for the State of Arkansas. He will serve as one of 17 members of the Council which is the governing body of the Association. Dr. Jacks has been very active in the Jefferson County Medical Society and is its current president.

Rex N. Moore, M.D., co-founder of the Marshall Road Medical-Surgical Clinic in Jacksonville, retired recently. A reception was held in his honor in Jacksonville.



New Members

BAXTER COUNTY

TerKeurst , John S., Urology, Mountain Home. Born October 22, 1947, Holland, Michigan. Pre-medical education, Tulane University, New Orleans, LA, 1970; Arkansas State University, Jonesboro, 1977. Medical education, University of Arkansas School of Medicine, Little Rock, AR, 1983. Internship, LSU Medical Center, Shreveport, LA, 1984. Residency, LSU Medical Center, Shreveport, LA, 1989. Member, Arkansas, Louisiana and Texas Urologic Societies.

CRAIGHEAD/POINSETT COUNTY

Fields, Brad, OB/GYN, Jonesboro. Born August 10, 1956, Hot Springs. Pre-medical education, University of Arkansas, Fayetteville, 1978. Medical education, University of Tennessee, Memphis, TN, 1984. Internship/ residency, University of Arkansas for Medical Sciences, Little Rock, AR, 1988.

CRAWFORD COUNTY

Harford, Martin Scott, Family Practice, Van Buren. Born October 6, 1951, California. Pre-medical education, Westark Community College, Fort Smith, AR; Oral Roberts University, Tulsa, OK. Medical education, University of Arkansas Medical School, Little Rock, AR, 1985. Internship/residency, Family Practice, Little Rock, AR. Board eligible. Member, American Associaiton of Family Practioners.

CRITTENDEN COUNTY

Clemons, Mark P., Otolaryngology, West Memphis. Born January 1, 1954, Memphis, TN. Pre-medical education, Emory University, Atlanta, GA, 1976. Medical education, Emory University, Atlanta, GA, 1980. Internship, Methodist Hospital of Memphis, TN, 1981. Residency, University of Tennessee, Memphis, TN, 1985. Practice experience, 4 years, Memphis, TN; 2 years, West Memphis, AR. Board certified, Otolaryngology.

McCalla, Mary R., ENT, West Memphis. Born February 16, 1952, Ozark, AL. Pre-medical education, Memphis State University, Memphis, TN, and the University of Tennessee, Memphis, TN. Medical education, University of Tennessee. Internship/residency, Methodist Hospital, Memphis, TN, 1987. Practice experience, 2 years. Board certified.

INDEPENDENCE COUNTY

Garst, Steve, Family Practice. Born August 29, 1942, Norman, OK. Pre-medical education, Butte College, 1969; Mysore University, 1971. Medical education, Christian Medical College, Ludiana Punjab, India, 1976. Internship/residency, University of Arkansas Medical for Sciences, Little Rock, AR, 1978. Practice experience, 8 years. Board certified. Member, Arkansas Academy of Family Physicians.

POPE COUNTY

Haines, Lynn Hart, Neurological Surgery, Russellville. Born 1940, Billings, MT. Pre-medical education, Montana State University, Bozeman, MT, 1962. Medical education, University of Washington School of Medicine, Seattle, WA, 1966. Internship/ residency , Jackson Memorial Hospital, University of Miami School of Medicine, 1976. Practice experience, 10 years. Board certified. Member, Congress of Neurological Surgeons, American Association of Neurological Surgeons and American College of Surgeons.

PULASKI COUNTY

Blasier, Robert Dale, Pediatric Orthopaedics, Little Rock. Born March 30, 1952, Garden City, MI. Medical education, Wayne State University, Detroit, MI, 1979. Practice experience, David Grant USAF Medical Center Travis AFB, CA, 4 years. Board certified, Orthopaedic Surgery.

Asche, Chris V., Gastroenterology/Internal Medicine, Fort Smith. Born March 24, 1949, Tempe, AZ. Medical education, University of Arkansas Medical Sciences, Little Rock, AR, 1979. Internship/residency, Brooke Army Medical Center, Ft. Hood, TX, 1982. Practice experience, 7 years. Board certified. Member, American Gastroenterologic Association, American Society for GI Endoscopy.

Christopher-Harmon, Pamela J., Family Practice, Fort Smith. Born, August 6, 1954, Memphis, TN. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1985. Internship/residency, AHEC, Fort Smith, AR, 1988. Member, AAFP.

Daily, Richard E., Aubulatory Care, Fort Smith. Born April 23, 1952, Mulberry, AR. Medical education, University of Arkansas School of Medicine, Little Rock, AR, 1979. Internship, Baptist Medical Center, Little Rock, AR. Practice experience, 10 years.

Heim, Stephen A., Orthopaedics, Fort Smith. Born May 15, 1956. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1983. Internship/residency, UAMS, 1988.

Marvin, Michael E., OB/GYN, Fort Smith. Born Feruary 10, 1950, Fort Smith, AR. Medical education, University of Oklahoma, Oklahoma City, OK, 1984. Residency, Scott & White, Temple, TX, 1988. Board

eligible.

Rosenzweig, Kenneth M., Orthopedic Surgery, Fort Smith. Born July 31, 1955, New Orleans, LA. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1982. Internship/residency, UAMS, 1988. Board eligible.

Schwarz, Julio M., Group Practice in Cardiology, Fort Smith. Born April 28, 1951, Guatemala City, Guatemala. Medical education, University of San Carlos, Guatemala, 1975. Internship/residency, Mt. Sinai Medical Center/Case Western Reserve University, Cleveland, OH. Fellowship, Cardiology. Board eligible. Member, AMA, ACC.

In Memoriam

A.W. Strauss, M.D.

Alvin W. Strauss Jr., a retired physician after 40 years, died Sunday, December 17, 1989. He was 69.

Dr. Strauss was past president of the Arkansas Academy of Family Practice, past chairman of the Arkansas National Guard Association, a retired colonel and commander of the Medical Battalion with the Arkansas National Guard, an Army vetern of World War II, and a former board member of his church.

Dr. Strauss is survived by his wife, Leslie Marks Strauss; two sons, Dr. Mark A. Strauss and Stanton L. Strauss, both of Little Rock; two daughters, Tracye Townley of Little Rock and Madolyn Rudolph of Atlanta, GA.; a sister, Mildred Weintraub of West Palm Beach, FL., and seven grandchildren

H. King Wade Jr., M.D.

H. King Wade Jr., owner and urologist of Wade Clinic for 41 years, died Sunday, January 7, 1989. He was 71.

Dr. Wade was past president of the American Urological Association, the Arkansas and the Garland County Medical Societies and the Urological Section of the Southern Medical Association. Dr. Wade served on several civic organizations and was a World War II Army veteran.

Dr. Wade is survived by his wife, Janet Gulley Wade; two sons, Dr. H. King Wade III of Denver, CO. and Dr. Paul D. Wade of Dallas, TX.; a sister, Ann Wade Lowery of Alexandria, LA., and four grandchildren.

James C. Dunbar, M.D.

James C. Dunbar, a retired physician, died Saturday, December 22, 1989. He was 68.

Dr. Dunbar is survived by several nieces and nephews.

RESIDENT SECTION

Hardy, Kyle G., Internal Medicine. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR., 1987.

STUDENT SECTION

Alderink, Carlisle

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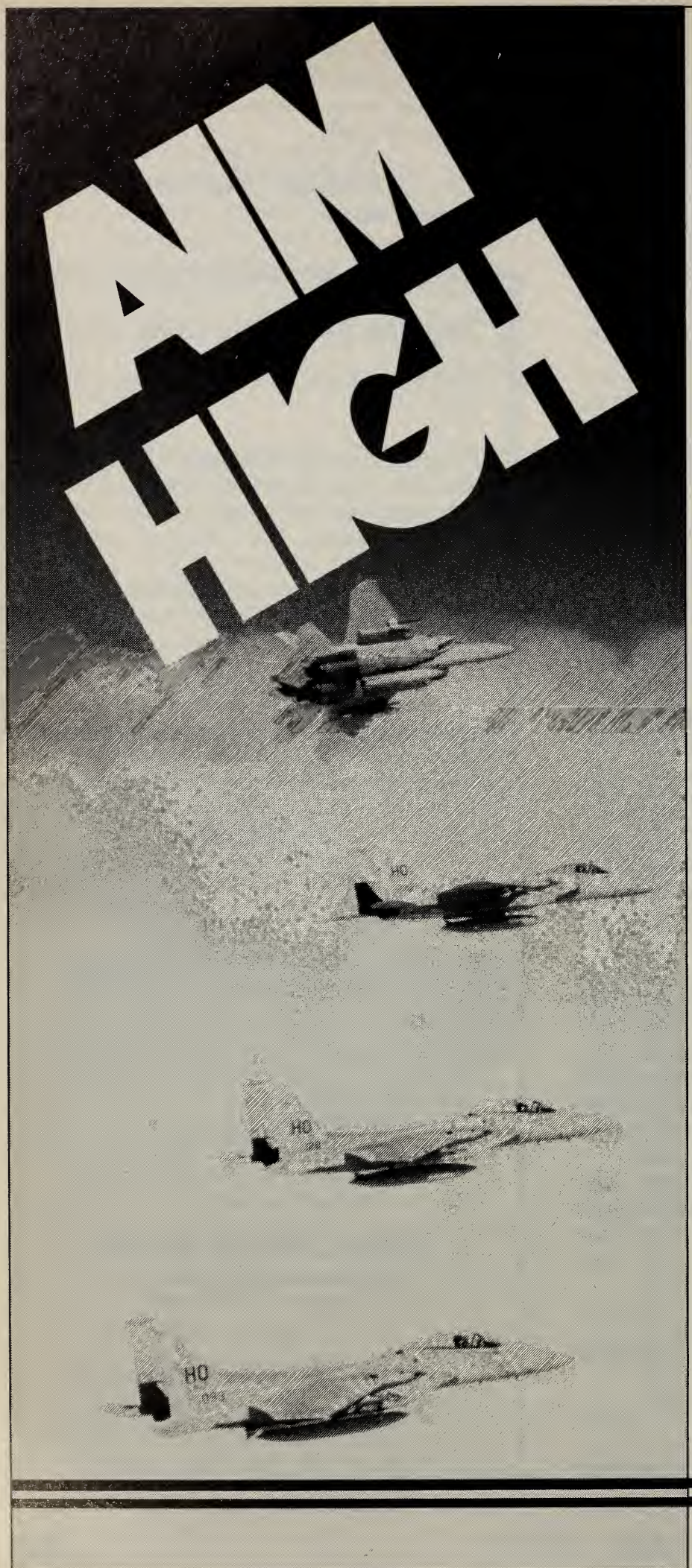
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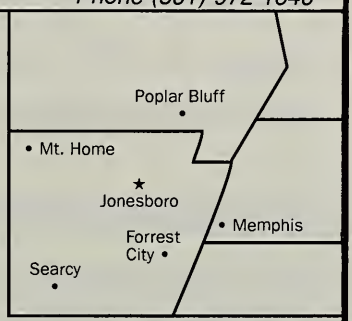
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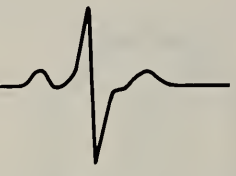
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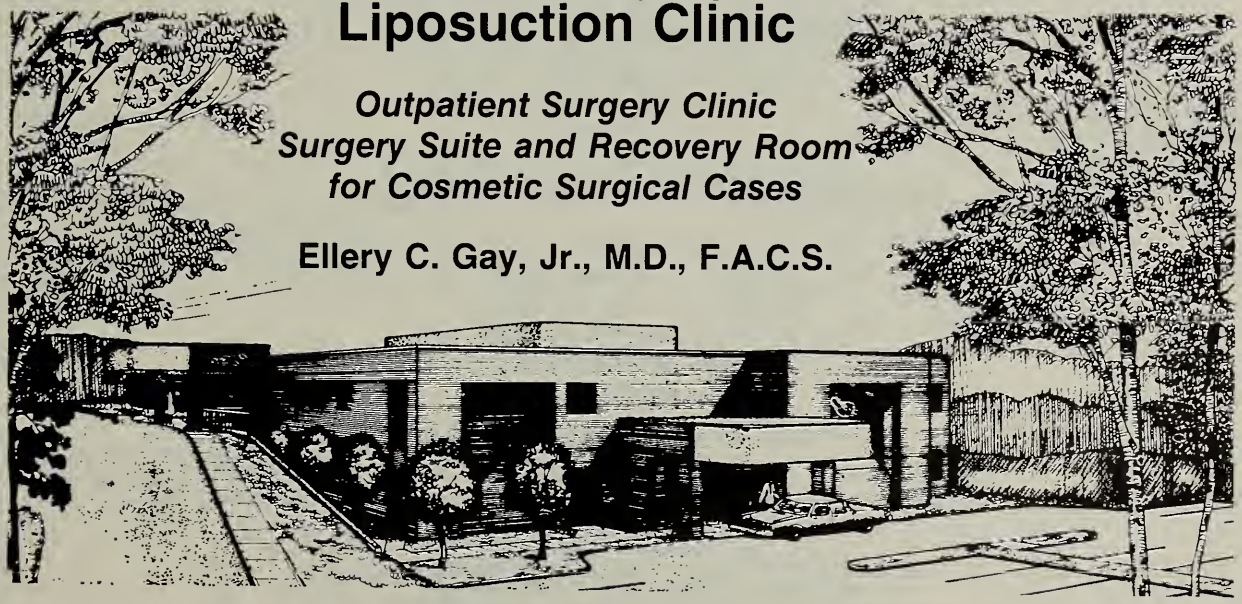
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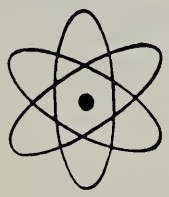
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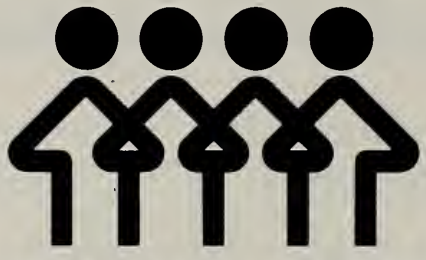
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VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy – Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teralogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest, pulmonary embolism and infarction, rhythm disturbances; atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis, stomatitis.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Herpes zoster, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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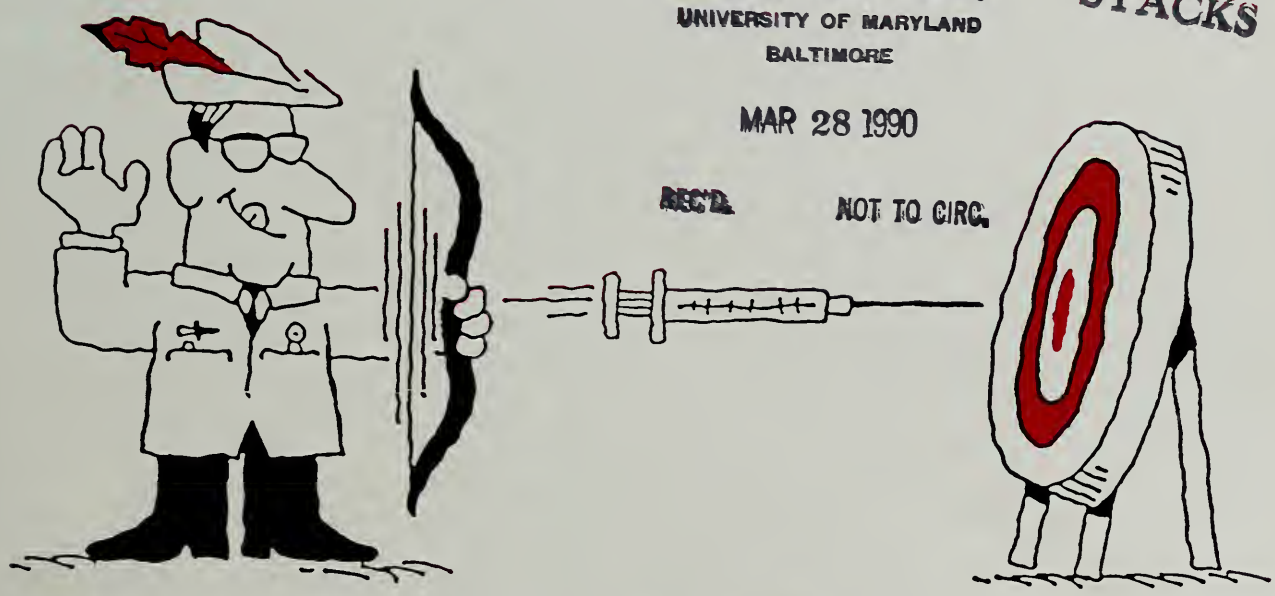
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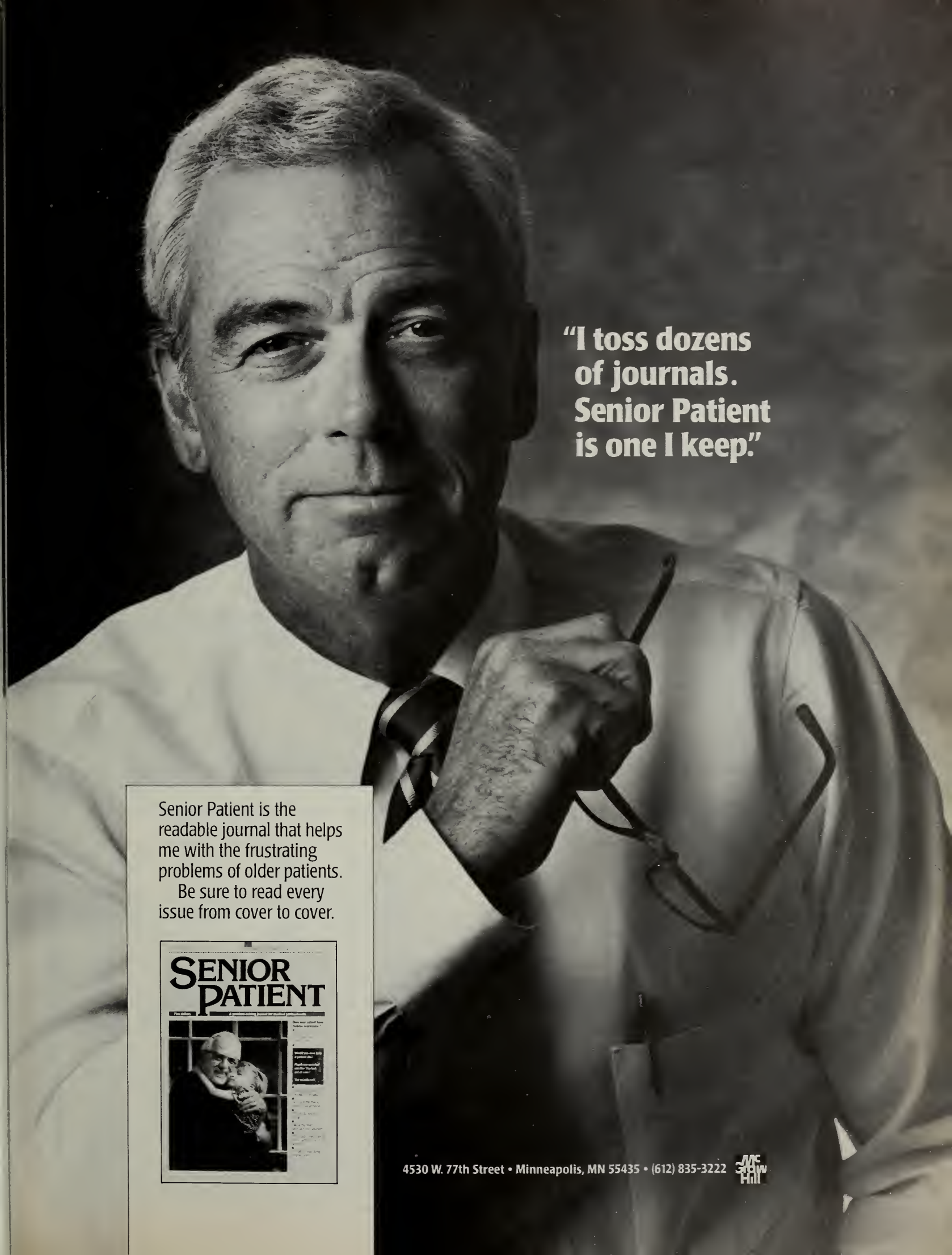
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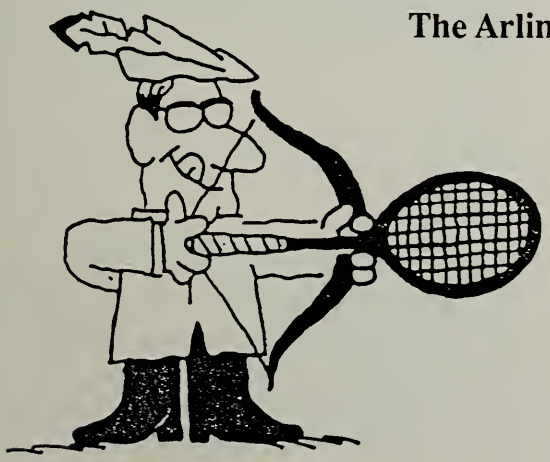
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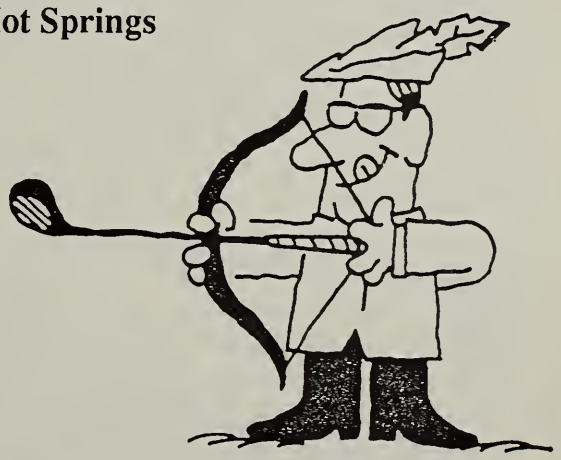
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AIDS IN ARKANSAS 1990
January 1 - December 31, 1990

Total number of cases reported	5
Number of deaths	0

CASES BY SEX

Male	5
Female	0

CASES BY RACE

White	5
Black	0
Other	0

CASES BY RISK GROUP

Homosexual/Bisexual	3
Homosexual & IV Drug User	2
IV Drug User	0
Hemophiliac	0
Transfusion	0
Heterosexual (Contacts)	0
NIR#	0

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	0
20 - 29	0
30 - 39	4
40 - 49	1
50 - 59	0
60 or more	0

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	0
Kaposi's Sarcoma	0
Pneumocystis Carinii and Kaposi's Sarcoma	2
Other Diseases	3

AIDS IN ARKANSAS
1985 - 1990

Total number of cases reported	257
Number of deaths	155

CASES BY SEX

Male	236
Female	21

CASES BY RACE

White	197
Black	58
Other	2

CASES BY RISK GROUP

Homosexual/Bisexual	167
Homosexual & IV Drug User	29
IV Drug User	27
Hemophiliac	2
Transfusion	12
Heterosexual (Contacts)	15
NIR#	5

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	3
20 - 29	81
30 - 39	119
40 - 49	34
50 - 59	12
60 or more	8

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	116
Kaposi's Sarcoma	11
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	124

Source: Arkansas Department of Health.

AIDS in Arkansas

AMS Committee on AIDS

Joseph M. Beck II, M.D.
Rebecca Edge Martin, M.D.

HIV Infection in Health Care Workers
What are the Risks?

Introduction

As the HIV epidemic spreads and more infected patients enter the health care system, risk of acquiring HIV in the health care setting will become more of an issue. The epidemiology of this infection has been delineated with the majority of exposures occurring through sexual or blood-born routes. Recently, however, much attention has been focused on health care workers who have acquired HIV infection in the health care setting. The purpose of this article is to summarize the data that is presently known and to put this risk into perspective among the other significant risks involved in caring for patients.

AIDS in Health Care Workers

As of January 16, 1989, 3,550 health care workers with AIDS had been reported to the Centers for Disease Control. These cases have been extensively analyzed, and in the majority, a known risk factor was identified. These cases do not included health care workers who seroconvert to HIV after a needle stick injury and it should be emphasized that these are retrospective studies. Facts which need to be borne in mind when considering health care workers with AIDS include the following:

1. 5.3% of all AIDS cases are in health care workers. Health care workers make up 5.7% of the total U.S. work force.

2. Health care workers are more likely to report no identified risk for AIDS exposure than non-health care workers (5.3% vs 2.8%). Reasons for this are unknown but may include under-reporting of risk behaviors for the fear of discrimination or loss of benefits rather than occupational exposure to infection. Of note is that the percentage of health care workers classified as having no identified risk has remained reasonably stable over time. Of 236 cases initially reported to the CDC as having no identified risk, 84 were reclassified into traditional transmission categories, 21 had died or refused further evaluation, 91 were still under investigation, and 40 of the 236 had completed the CDC interview and remained no identified risk. Of these 40, 16 had had at least one needle stick in the past ten years, leaving 24 of the 236 initially reported as no identified risk as having had "no exposure". An interesting fact brought out during this analyses was that 73% of the 40 workers were male, although according to the United States Bureau of Labor, 77% of U.S. health care workers are female.

Although it is difficult to make absolute statements from the preceding data, one logical conclusion is that if large numbers of health care workers were being infected by unknown means, then health care workers most likely to come in contact with patients and/or blood products would be those becoming infected. Nursing, laboratory and phlebotomy jobs are traditionally female, yet as noted above, 73% of the non-identified risk AIDS patients are males.

Documented Seroconversion to HIV

Although obtaining accurate histories regarding high risk behavior for HIV among health care workers is difficult, there are several well documented cases of occupational transmission of HIV in health care settings.

It is estimated that the risk of HIV infection after a needle stick injury is 0.4% (1 in 250). Currently, the CDC is aware of 17 documented HIV antibody seroconversions among health care workers, 15 of which were due to needle stick injuries and two which will be discussed later, from significant mucous membrane exposures. These cases are important because HIV antibodies drawn at the time of the accident were negative and the health case worker seroconverted at a later date. These case reports document an occupational risk fo HIV transmission; the risk, however, is thought to be small. In a summary of published prospective studies for the risk of occupational transmission of HIV-1 following percutaneous exposure, a total of 1,320 health care workers were studied with 1,389 percutaneous exposures reported. There were five seroconversions, at a rate per event of 0.36%. Clearly, a percutaneous inoculation is the riskiest injury for transmission of HIV in the health care setting.

The remaining two workers had a significant mucous membrane exposure to blood from HIV infected patients. These were characterized by large amounts of blood, the most infectious body fluid known, on mucous membrane or non-intact skin. Of note, there have been at least eight studies evaluating health care workers who reported a mucous membrane exposure to blood or body fluids. In these prospective studies, 538 health care workers have reported a total of 921 mucous membrane exposures with no seroconversions. Statistically, the upper limit of the confidence range for rate of transmission per mucous membrane exposure is 0.33% but the actual risk is most likely to be significantly smaller.

Of interest are studies among health care workers involved in the care of HIV positive patients who do not report an adverse exposure. There are several ongoing studies which pooled have followed a total of 929 health care workers for at least six months and some for many years. No seroconversions in the absence of adverse exposure or other risk factors can be documented.

Issues and Testing

In the past few months several studies have been published reporting HIV viremia in patients who are both HIV antibody negative and Western Blot negative. The virus is recovered through culture in these patients and also through the polymerase chain reaction. This is a relatively new method of DNA amplification, wherein many copies of viral DNA are made enabling bits of the HIV genome to be identified by a DNA probe. In one study, as many as 20% often high risk patients with ongoing exposure to HIV infection were polymerase chain reaction (PCR) positive and culture positive for HIV while ELISA negative. This data is also suggested by ongoing studies of sexual partners of infected transfusion recipients. Others have been unable to corroborate this data and suggest that this may only be a factor in people with ongoing repeated high risk exposures. Dr. Julie Gerberding of San Francisco General Hospital has done polymerase chain reactions in over 200 health case workers who had needle sticks with HIV infected blood. All of these workers were HIV and Western Blot negative. She found four positive polymerase chain reactions which were negative when repeated. Her conclusion is that these were false positives due to contamination. In addition, elegant studies of household contacts of HIV-infected patients suggest minimal risk associated with care giving activities. The magnitude of risks for occupational transmission of HIV in the absence of an adverse event is so small as to currently elude estimation and in all likelihood is below the limits of dection.

Possible Influencing Factors

Several factors are thought to influence the risk for occupational transmission of HIV infection. These include route of exposure (intravenous vs subcutaneous), depth of injury, size of defect in the integument (needle stick vs laceration), body fluid (blood vs other), and donor's severity of HIV related illness. In addition, infectivity may be influenced if the donor is receiving antiviral chemotherapy or has concurrent viral infections, such as EBV or CMV, resulting in lymphocyte proliferation or "turned-on" cells. Reason argues that some, if not most of these factors, contribute to risk but definitive studies are pending.

Conclusions

There is a small but measurable risk of HIV transmission in the health care setting. This risk is not excessive when compared to other risks health care workers have been facing for years. For example, it has been estimated by OSHA that there are 12,000 new cased of Hepatitis-B infection related to occupational exposure in health care workers in the United States annually and that between 150 and 200 health care workers die from occupationally acquired Hepatitis-B each year. The health care setting is not a risk free environment and many infections with serious consequences are known to be transmitted including mycobacterium tuberculosis, rubella virus, Hepatitis-C, etc. In the past, such risks have not precluded the provision of high quality health care and when assessed in the appropriate context, the risk provided by AIDS/HIV infection does not seem to warrant the attention it has received.

Recommendations

1. We do not recommend routine, mandatory testing of patients for HIV either in the medical or surgical setting. This is in accordance with the CDC and most other authorities. Reasons for this include the likelihood of false positives in a low prevalence area and complacence among health care workers in delaying with HIV antibody negative patients. We know that patients may test negative for HIV antibody but actually be infected and able to transmit virus (ie: if in the window period between infection and antibody production).

2. Health care workers should be tested for HIV after adverse exposure to infected blood. Routine confidential surveillance for HIV antibody should be offered, but not required, of workers who have frequent direct contact with HIV patients. Surgical, emergency department and laboratory personnel dealing with frequent blood contact should also be offered surveillance testing.

3. Universal precautions for blood and blood containing body fluids should be followed as per CDC recommendations.

4. Special precautions for health care workers performing invasion procedures should include latex gloves, masks, gowns, and protective eye wear. For procedures likely to produce splashing of body

fluids or to generate bone chips, respirator industrial masks, full face shields, double shoe covers, gowns or aprons made of material providing effective barriers should be available. Water impermeable protective boots to the knee should be provided for a procedure with the likelihood of blood or irrigation fluid overflowing the wound and drapes.

5. Sharp instruments, needles, scalpels, etc., should be passed with the basin during surgery, only one instrument at a time.

6. Needles should not be recapped while health care workers are holding the cap.

7. Inexperienced personnel should, if at all possible, not be performing invasive procedures until they have become proficient in them. This includes blood draws, lumbar punctures, and bone marrows on any patient with a known blood-borne viral infection such as HIV or Hepatitis-B. There is some evidence to suggest that patients with symptoms from HIV may will be more infective than asymptomatic ones, and while we realize that this may not be practical in all instances, it should be encouraged if at all possible.

Management of Exposure

We feel that all health care workers should know what person or department in the hospital or clinic to contact immediately after exposure. AZT (Retrovir, zidovudine) should be offered in full dose for exposures deemed significant by the physician. If the health care worker desires to take AZT, informed consent including unknown long-term risks should be obtained. If the injury occurs in the hospital, the AZT should be furnished by the institution and the cost should not be borne by the health care worker. If at all possible antiviral therapy should be begun one hour after exposure. There are no human data to support this and the animal data is contradictory. One animal study suggested efficacy, one did not. However, a randomized, double blind, placebo controlled trial will be impossible because few would be willing to serve as controls. Therefore, prophylactic AZT for significant exposure is recommended. HIV serology should be done immediately post exposure and if negative, repeated at six weeks, twelve weeks, and at six months following exposure. There has never been a known seroconversion of a health care worker longer than six months after exposure.

Conclusions

HIV infection among health care workers is due to recognized risk factors in the overwhelming majority of cases. The risk factors include sexual exposure, illicit intravenous drug use, and nonsocial exposures. Most documented seroconversions in the health care settings are due to needle stick injuries with HIV contaminated needles and the risk of acquiring HIV in this way is present but very small. Efforts should be made to minimize exposure to blood and infectious body fluids and to strengthen safety procedures in dealing with sharp contaminated objects.

Acknowledgement

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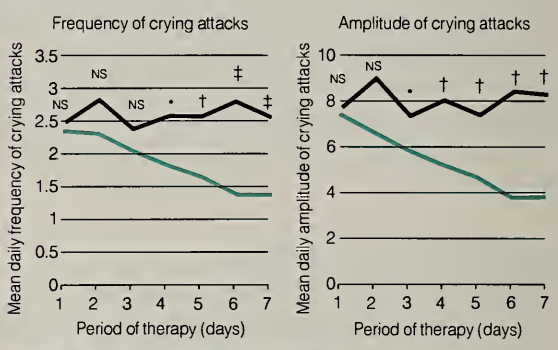
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Follow Up Outcome of Intracavernous Papaverine

Amer Z. Al-Juburi, M.D. and Pat D. O'Donnell, M.D.*

Abstract

One of the more significant recent therapeutic developments in the treatment of male impotence has been intracavernous pharmacotherapy using penis self-injection technique. The intracavernous pharmacotherapy of impotence results in a relatively normal erection in most cases with minimal alteration of the anatomy, physiology, and psychosocial factor of impotence. However, early treatment success of the patient does not assure long-term success. The objective of this study was to determine the long-term utilization outcome of intracavernous pharmacotherapy in the management of impotence. Of 103 enrolled in the study, 50 patients (49%) were actively using the injection treatment method after 18 months. There were no significant difference in mean age of those patients who discontinued from those who continued to use intracavernous therapy. Of the 53 patients (51%) who discontinued intracavernous therapy, 33 patients (62%) were unsatisfied with the results, nine patients (17%) were unsatisfied with the methodology, eight patients (15%) developed penile complications, and three patients (6%) had improvement of sexual function. Thirty-four (69%) of those who discontinued therapy elected an alternative form of therapy and 16 patients (30%) were not interested in any further treatment. While it is difficult to assess the many factors involved in the outcome of therapy for impotence, the assessment of long-term intracavernous therapy utilization provides a relatively low risk means for clinical evaluation of the therapeutic value of pharmacotherapy for the individual as well as a clinical indication of the sexual function needs of the patient.

Introduction

Male impotence is a complex disorder affecting approximately 30 million men in the United States. Non-operative impotence management programs appear to have a major role in the current management of male impotence (1,2). The most significant recent therapeutic development has been intracavernous pharmacotherapy (3-8). An important aspect of intracavernous pharmacologic management of impotence is the ability of a physician to provide the patient with a means of sexual function that has a relatively low risk to the patient. The pharmacologic induced erection is of a relatively normal physiologic nature and provides the patient with a method of having an erection sufficient to achieve vaginal penetration with minimal alteration of his anatomy, physiology, and psychosocial environment. The actual impact of impotence on the life situation of the individual, as well as the sexual motivation of the couple, can be assessed, to some extent, with intracavernous pharmacotherapy by eliminating the inability of the male partner to achieve an erection. Follow up of the patient can determine his response within his environment to the pharmacologically-induced erectile function and his utilization of the treatment option. The objective of this study was to determine the long-term utilization outcome of intracavernous pharmacologic management of impotence using a self-injection technique.

Material and Methods

An 18 month follow up of 103 patients treated with penile self-injection technique for impotence was done. The mean age of the patients was 60.6 (SD=8) with a range of 32 to 73 years of age. Patients presenting with a history of impotence requesting treatment of the disorder were counseled regarding intracavernous therapy. Those patients who elected intracavernous therapy were instructed in the technique of injection and 0.5 ml (15 mg) of papaverine was injected during the initial visit. The dose of papaverine was increased according to the response in each patient up to 2 ml. If a satisfactory erection was not obtained with 2 ml injections of papaverine, a 30:1 papaverine-phentolamine solution was injected starting with smaller doses and increasing up to a maximum of 2 ml of the combination solution. For doses of 1.0 ml or less, a tuberculin syringe and needle were used. For doses over 1.0 ml, a 3 ml syringe with a 27 gauge 1/2 inch needle was used.

Initiating intracavernous pharmacotherapy using an intracavernous injection of 15 mg of papaverine and gradually increasing according to the needs of the patient greatly reduced the problem of priapism. In addition, adequate patient education in the use of the intracavernous therapy minimized problems of priapism. Once the patient was comfortable with the procedure, the frequency of injection commonly was about 2-4 times per month. The couple was advised to avoid intercourse more than twice a week with a minimum time of two days between injections.

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Follow up clinical assessment of response to therapy was done by assessment of the time of onset of erection, the duration of response, the quality of the erection, and the couple satisfaction. Adjustments of the dose of the injection were made during the 18-month follow up period based on the intermediate assessments.

Results

Of the 103 patients begun on intracavernous pharmacologic therapy using the penile self-injection technique, 50 patients (49%) were actively using intracavernous therapy after 18 months of treatment. Fifty-three patients (51%) had discontinued use of intracavernous therapy during the 18 months. The age of patients who discontinued therapy (60.8 years old, SD=7.5) was not significantly different from those who continued to use intracavernous pharmacotherapy (60.3 years old, SD=8.4).

The most frequent reason given for discontinuing the intracavernous therapy program was that the couple was unsatisfied with the management program. Of the 53 patients who discontinued the intracavernous program, 33 patients (62%) were unsatisfied with the therapeutic results. Nine patients (17%) were unsatisfied with the methodology required to achieve an erection. Eight patients (15%) discontinued the treatment program due to penile complications. Three patients (6%) had improvement of sexual function and discontinued the treatment program because it was no longer required.

Of the 53 patients who discontinued therapy, 34 patients (64%) elected an alternative form of therapy which included penile prostheses and erection assistance devices, 16 patients (30%) were not interested in any further treatment, and three (6%) no longer required therapy.

During the clinical follow up period of patients who continued therapy, those treated with papaverine alone had an onset of erection within five minutes in 77% of the patients compared with the Papaverine-Regitine patients in whom an erection occurred within five minutes in only 34%. The duration of erection in patients treated with papaverine alone was greater than one hour in 23% of the patients compared with 50% of patients receiving Papaverine-Regitine.

There were 25 complications (24%) that occurred during intracavernous therapy over 18 months in this group of patients. In two patients, a cerebral vascular accident occurred and neither appeared to be directly related to intracavernous pharmacotherapy. One patient developed a leaking cerebral aneurysm approximately three weeks following initiation of intracavernous therapy. The incidence of prolonged erections in this group was 6%. After a more extensive patient education program was implemented, the occurrence of prolonged erection has become rare.

In patients having erections for longer than six hours, the initial management included Epinephrine injection at the same corpus site as the previous papaverine injection using 1 ml of a 1:1000 Epinephrine (Park-Davis) in 24 ml of 0.9% saline using a 25 ml syringe. Prior to intracorporal infusion of Epinephrine in these patients, each was placed on a heart monitor and begun on intravenous fluids. If detumescence did not occur within two hours, a saline irrigation of the corpora cavernous also was done.

Discussion

The etiology of impotence can rarely be specifically identified clinically as a single abnormality and usually involves a combination of anatomical, physiologic, psychological, and social factors. The role of each factor is difficult to evaluate in the assessment of an individual with impotence in order to establish an etiology. It is not possible in most cases to provide treatment for an individual based on the specific etiology of impotence. Also, it is difficult to identify the sexual function needs of an impotent patient as well as to determine the impact of impotence on the individual relative to his particular life style. Integrating the physiologic, psychologic, and environmental factors in the therapeutic decision process is clinically complex. At the present time, none of these various factors related to impotence are able to predict outcome of treatment. There are many clinical issues involved in the long-term management of impotence which cause efficacy of therapy to be a problem to assess. For example, the ability of a patient to achieve vaginal penetration is not in itself a measure of successful treatment for impotence. The satisfaction of sexual function by an individual and his sexual partner is a major issue in successful therapy but is somewhat of an elusive concept and difficult to quantitatively measure. Treatment outcomes based on long-term clinical efficacy and utilization seems to be a satisfactory approach to patient selection for continued therapy.

The results of this study demonstrates the efficacy of intracavernous pharmacotherapy in the treatment of impotence over a long period of time for some patients. It also demonstrates that a number of patients are not suited to this type of therapy and voluntarily discontinue its use for numerous reasons. Intracavernous pharmacologic therapy provides the physician and the patient with an opportunity to assess, to some extent, the utilization by the patient of a potency augmentation method and to assess, to some extent, the need for providing an alternative form of therapy for the patient. In this clinical evaluation of impotent men, the physiological, psychological, social, and environmental factors are likely related, to some extent, to the continued use of the treatment modality by the individual.

Since there are no reliable measurements prior to therapy to adequately assess the sexual function requirements of a patient and his partner and the impact of sexual inactivity on the overall lifestyle of the individual, a trial of intracavernous therapy can provide, to a limited extent, a clinical index of the sexual motivation and sexual activity needs of the patient. With the extremely large number of people affected with impotence, no single therapeutic modality provides a treatment of choice for all patients. The

initial use of intracavernous therapy for treatment of impotent man ultimately enhance the subsequent utilization of all forms of impotence management through expanding the treatment options available for a larger population of people who are affected. For example, in those patients having frequent utilization of intracavernous therapy over a long period of time, converting the patient to management with a prosthesis may be an important consideration due to the long-term complications of intracavernous therapy. Those patients who are not satisfied with the results of intracavernous therapy also may be considered for management with a prosthesis, although it is important to recognize that the long term sexual motivation and the sexual activity needs of the patient have not been established. Although further studies are needed, it is likely that patients having infrequent sexual activity may be the most appropriate group for long- term intracavernous pharmacotherapy. Those having frequent sexual function requirements and those unsatisfied with the injection method may be more appropriately managed with an alternative form of therapy.

Conclusion

Approximately 1/2 of the patients initially managed with intracavernous pharmacotherapy for the management of impotence discontinued treatment over 18 months follow up. Since current pretreatment testing procedures have not been established for predicting outcome of therapy, a clinical trial of intracavernous treatment can be used to determine treatment response and ling utilization.

Although further studies are needed, patients having frequent use of intracavernous therapy appear to be at risk for fibrosis and the option for alternative therapy should be presented to the patient. Those patients unsatisfied with the outcome of intracavernous therapy should be presented the option for alternative therapy although long- term sexual activity has not been established. Follow up evaluation of intracavernous therapy can allow, to some extent, clinical assessment of the sexual activity status of the patient with impotence.

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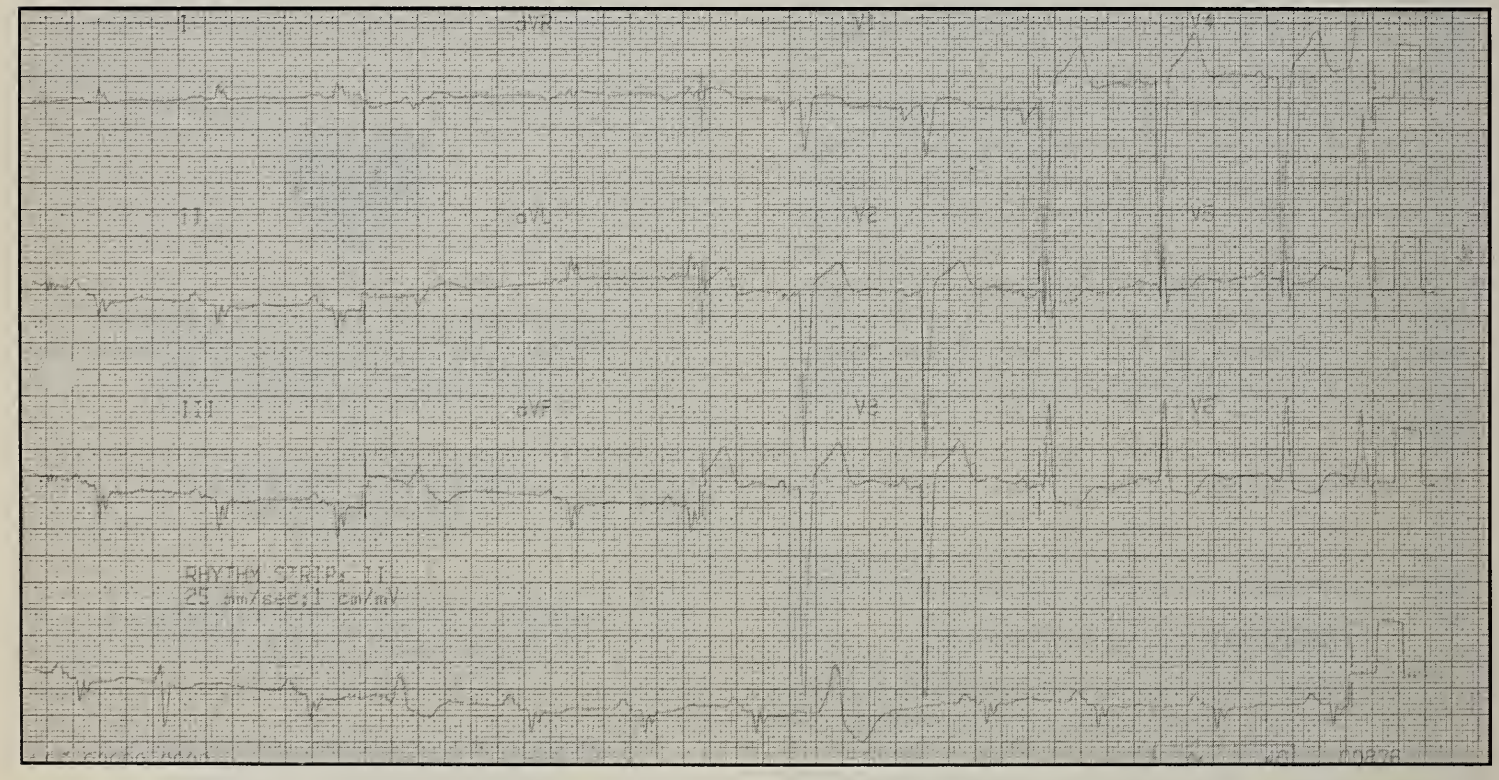
ELECTROCARDIOGRAM of the MONTH



William C. Furlow, M.D.
John W. Watson, M.D.
Division of Cardiology
UAMS, Little Rock, Arkansas

CLINICAL HISTORY:

P.N. is a 65-year-old woman who presented to the hospital because of crushing substernal chest pain of two hours duration which was associated with intense diaphoresis. Her past history was positive for strokes and hypertension. Her cardiovascular examination revealed hypertension, pulmonary crackles, an S3 gallop, and a murmur of mitral regurgitation. What do you think of her electrocardiogram?



DISCUSSION:

Sinus rhythm is noted. Classic changes are present for left atrial and left ventricular hypertrophy. The trace suggests the presence of past inferior and septal infarctions. Old electrocardiograms as well as sequential traces would be of great value for evident reasons.

The editor wishes to thank Dr. Furlow, who practices internal medicine and cardiology in Conway, Arkansas, for his assistance with this month's featured electrocardiogram.

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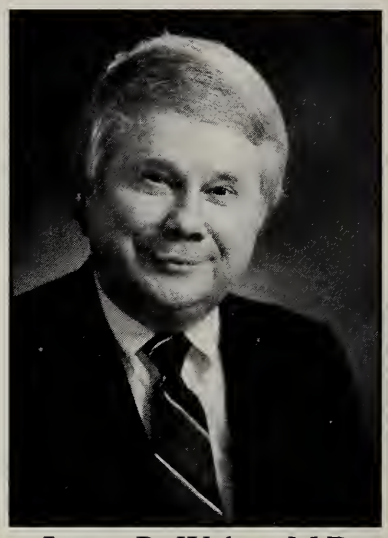
Medical Education Is The Solution

The Patient is "Outraged".... The Physician Responds!

(A Factual Explanation of the Medicare Maze)

The following is a reprint of the actual correspondence between a Medicare recipient and James R. Weber, M.D., the current president of the Arkansas Medical Society. The patient's letter reflects the thinking of many of our elderly citizens. Unfortunately, most doctors don't take the time to explain that the so-called "Medicare reasonable fees" are not reasonable. In fact, increases have been minimal or non-existent since the programs inception in 1973 and are unrealistic when compared to the actual cost of providing medical service.

Both parties copied their U.S. Senators and hopefully our lawmakers took note of the inequities of the Medicare program. The patient's name has been omitted to protect the doctor/patient confidential relationship.



James R. Weber, M.D.

Letter to Dr. Weber from Patient:

September 9, 1989

James R. Weber, M.D.
1110 West Main, P.O. Box 188
Jacksonville, AR 72076

Dear Sir:

I am outraged! Your bill to Medicare for one office examination was $113.33. They approved only $44.90 and paid $35.92.

In an effort to keep our medical bills reasonably current, we pay $103.66 each month for a supplemental insurance policy. They base their payments on the Medicare approved amount, paying the difference between the approved amount and the Medicare payment. In this case they will pay $8.98. This means, in addition to Medicare and a good supplemental policy, I still must pay you $68.43 for one call.

Your office people told me, in advance, that you won't accept Medicare assignment so I knew I would have to pay something. The outrageous thing is that your charge is over 2 1/2 times what Medicare will approve and we were not given an advance indication of that.

I was not curious enough to ask what your over-charge would be so I guess I will have to pay it.

Your office was not forthright enough to notify us, in advance, what the over-charge would be so I guess you will have to live with the payment schedule as outlined below.

I am enclosing the endorsed Medicare check in the amount of $35.98 for you to apply to this account. I will pay the balance in an amount no less than $10.00 per month, which is something I can live with.

Sincerely,

Patient's name omitted

cc: Senator Dale Bumpers

Letter to Patient from Dr. Weber: 10/17/89

Dear_____:

Thank you for your letter. Like you, I am also outraged. As president of the Arkansas Medical Society, I have been working hard to help change such low reimbursement by Medicare in Arkansas.

It is unbelievable that Medicare in Arkansas allows only $44.90 and reimburses only $35.92 (80% of $44.90) for a comprehensive evaluation and management office visit (CPT-4 code 90080).

Enclosed is a copy of the medical record generated from the comprehensive evaluation of your wife, _____, on August 31, 1989. You will note that she has complex and serious multiple medical problems and that this was the first visit for me to see her as a patient. You will note that the record generated from this visit alone consists of three, single spaced, typewritten pages. Payment for the medical transcriptionist service alone to produce this record at $.08 per line is almost $10.00.

My actual overhead expense for a comprehensive office visit today is $110.00 (cost of one hour of office time). You can readily see that the Medicare payment of $35.92 is less than 1/3 of my cost of providing this service for your wife. My office overhead expense is average for this area.

I do accept Medicare assignment on a case by case basis. For example, if a patient is below the federal poverty level in income or has unusual financial hardship, I do accept assignment of medicare, even though this payment is only 30 to 40% of my cost of providing the service (put another way, I personally pay 60 to 70% of the cost of that patient's medical care). In those cases where I do not take assignment, I am always happy to work out a payment schedule on an individual basis, such as you have offered ($10.00 per month) and one that you can live with. That is acceptable to me.

You may be interested to know that the hospital Emergency Room doctor called me personally to ask if I would accept your wife as a new patient. He indicated to me that she had made several visits to the hospital ER and that in his opinion, the comprehensive and continuing care necessary for her could not be properly given through recurrent ER visits. I reviewed these ER records, and I agree with him. Note that the cost of the first ER visit was $464.75 and the cost of the second visit was $181.00. He also indicated to me that he was unable to find a physician to accept her case at the time he called me and I agreed to do so.

I want to point out to you that the Medicare maximum allowable charge for a comprehensive office visit in Arkansas is $113.33. This is the amount I charged for your wife's services. You may not be aware of the levels of evaluation and management services (office visits), both under Medicare and other private insurance. Your wife's services were not (just a simple office visit) as you perceived. Enclosed is a copy of the Arkansas Blue Shield payment schedule for office visits. Their payment for a comprehensive office visit, such as given to _____ (90080) is $130.00, Medicare's allowable payment is $44.90, and my cost of providing this service is $110.00

The fact that the Medicare program in Arkansas reimburses primary care physicians at the incredibly low rate of 30 to 40% of the actual cost of providing the care means that when the doctor takes assignment, he or she personally picks up the tab for 60 to 70% of the cost of the care. In such cases in Arkansas, the physician personally pays more for the medical care of the patient in the office than the government pays. As previously stated, I still do this in all cases of hardship. I do carry a very significant load of these patients at this time. It should be obvious to anyone that any physician cannot afford to take on a lot more Medicare patients with assignment in Arkansas without going out of business. It is true that these low payments for office visits and consultations by Medicare in Arkansas are creating a serious problem of access to care for Medicare patients in many areas of the state. I am very concerned about this. I hope that our senior citizens, such as yourselves, will be even more concerned when they understand the real problem and will join with us in trying to correct these inequities.

Our Congress and Senate are presently trying to correct these problems by passing a reimbursement system for Medicare Part B (physician services) based on a relative value scale calculated from the resources involved in providing the service, rather than the faulty system being used today (the new system is called Resource Based Relative Value Scale). I have enclosed the names and addresses of each of our senators and congressmen from Arkansas in case you want to write them supporting (RBRVS) and send them copies of our letters as a real example of the problem as it exists today.

If your income falls below the federal poverty level or simply if you are having financial hardship, I would gladly agree to accept assignment in your case, even though I will be personally paying for 60 to 70% of the cost of your wife's care.

If you have decided to seek care elsewhere, as you indicated, I have enclosed a copy of your wife's record. I will be glad to provide any needed service until you are established with another physician or I will be glad to accept your wife as an ongoing patient, either on an assigned basis or unassigned basis, depending upon your individual situation. Your wife has serious, multiple, complex medical problems that will require continued and comprehensive medical care. I take great pride in this community in that so far, we have not refused care to anyone in need, regardless of their ability to pay.

Sincerely,

James R. Weber, M.D.

Enclosure
cc: Senator David Pryor
cc: Senator Dale Bumpers

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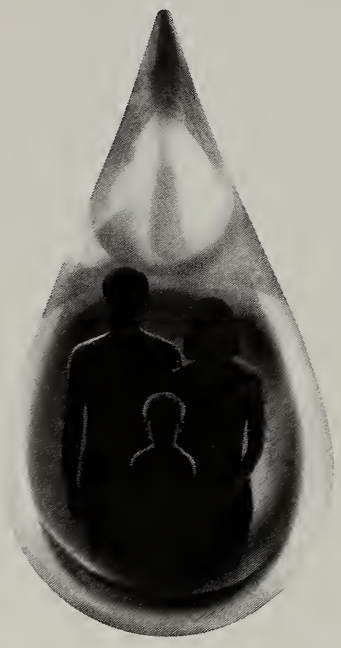
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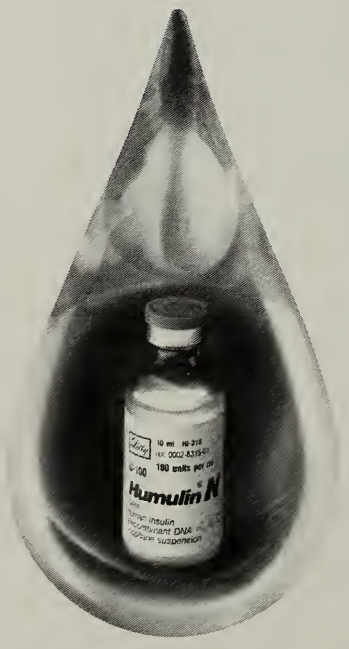
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And God Said, "That's the Idea"

J. Kelley Avery, M.D.*

God said, "Cane, where's Able"?
Cane said, "I have enough trouble looking after myself.
Am I supposed to look after that character, too"?
And God said, "That's the idea."

Case Presentation

A 29-year-old female, having found a knot in her right breast while taking a shower, was sent by her primary care physician to see Dr. White, a general surgeon. After examination, Dr. White ordered a mammogram, which was reported as showing a small mass but "no obvious sign of malignancy." Dr. White admitted the patient for an outpatient excisional biopsy. The mass was small and the radiologist assisted in locating the mass by using a needle wire guide.

Under brief general anesthesia, the mass was removed and the post-operative note by the surgeon stated, "Lesion totally removed with the wire guide remaining in place." The path report confirmed that the lesion was totally removed but made no mention of the wire guide.

The patient returned for the routine visits. Her incision healed nicely, and at a 3 month post-op visit all was well and no further follow-up appointments were made.

Thirteen months later the patient went to see Dr. Green, a surgeon in the same city on the same large hospital staff as Dr. White. Her complaint was pain in the right breast, "ever since my breast was operated on last year." She indicated that the pain was much worse in the past two weeks. A mammogram ordered by Dr. Green showed a small metallic object that appeared to be "a fragment of needle or wire." Dr. Green proceeded to remove the small fibroma that had developed, along with the 5mm piece of the previously used needle guide wire.

The patient did well post-operatively but filed a lawsuit against the first surgeon. After the usual long length of time taking the necessary statements, depositions, filing motions, etc., a small settlement was required.

Case Discussion

This case is not very important from the standpoint of monetary loss, but it is extremely important to Dr. White, the accused surgeon. He justly feels the victim of a system that was not inclined to treat him like the good and caring physician he believes himself to be. Several aspects troubled him:

1. The patient never complained to him of pain post-operatively. His notes make no mention of pain, and he knows he would have paid attention to such a complaint.

2. He looked at the needle guide and noted in his post-operative note that it had been removed.

3. He didn't pay attention to the lack of any mention of the wire in the path note. It is the policy of the hospital to send <u>everything</u> removed at an operation to pathology. He assumes they did and that the pathologist failed to mention the guide because it was so incidental to the main lesion.

4. He didn't even know that a colleague had seen his patient and removed the small piece of wire until the suit was filed.

It is true that Dr. White is a good and caring physician. He has good rapport with his patients and generally enjoys his contact with them. He is active on his hospital staff and has never had any question raised about the quality of the care he gives to his patients. No one doubts that Dr. White looked at the removed needle guide and truly believed it to be completely intact.

Be that as it may, the intra-operative notes made by the OR nurse failed to mention a guide wire, but on deposition she stated that she <u>knows</u> she put the wire in the container with the tissue specimen if it was given to her, because, "That is our routine, and I always do it." As a matter of fact, the OR nurse admitted that she had no real recollection of the events that day in the outpatient OR almost three years before. She had to rely totally on the notes she made at the time.

The pathologist's testimony was very similar in that he had no real recollection of the event; however, he was

**Dr. Avery is chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood and Medical Director Ambulatory/Outpatient Services, St. Thomas Hospital, Nashville, TN.

even stronger in insisting that had the needle guide been included in the bag with the specimen, it would certainly have been part of the report.

There is no indication that Dr. Green openly criticized Dr. White's care. He was not guilty of jousting in the sense that he really "knocked Dr. White off his horse." But neither could we assume that Dr. Green's conscious purpose was to scrupulously avoid contact that could be interpreted as critical to Dr. White's care. We don't know what Dr. Green said to the patient, but he didn't call his colleague and inform him of the visit of the patient and the presence of the small foreign body . We have no reason to believe that he said to the patient, "Look--Dr. White is a good surgeon. Things like this happen frequently. At the worst, it's an honest mistake, and we really don't even know who made it. Why don't you let me call Dr. White and discuss it with him? I'm sure he'll remove it and not even charge you a fee." Had that been the spirit of the approach used by Dr. Green, there is a better than even chance that the patient's anger would have been softened and a satisfactory resolution could have been reached without involving lawyers. Our relationship to our patients and each other is almost never adversarial until, or unless, attorneys are brought into it. So it makes good sense to keep them OUT, whether they are after us or our colleagues.

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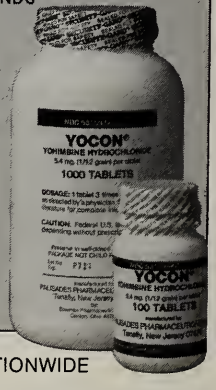
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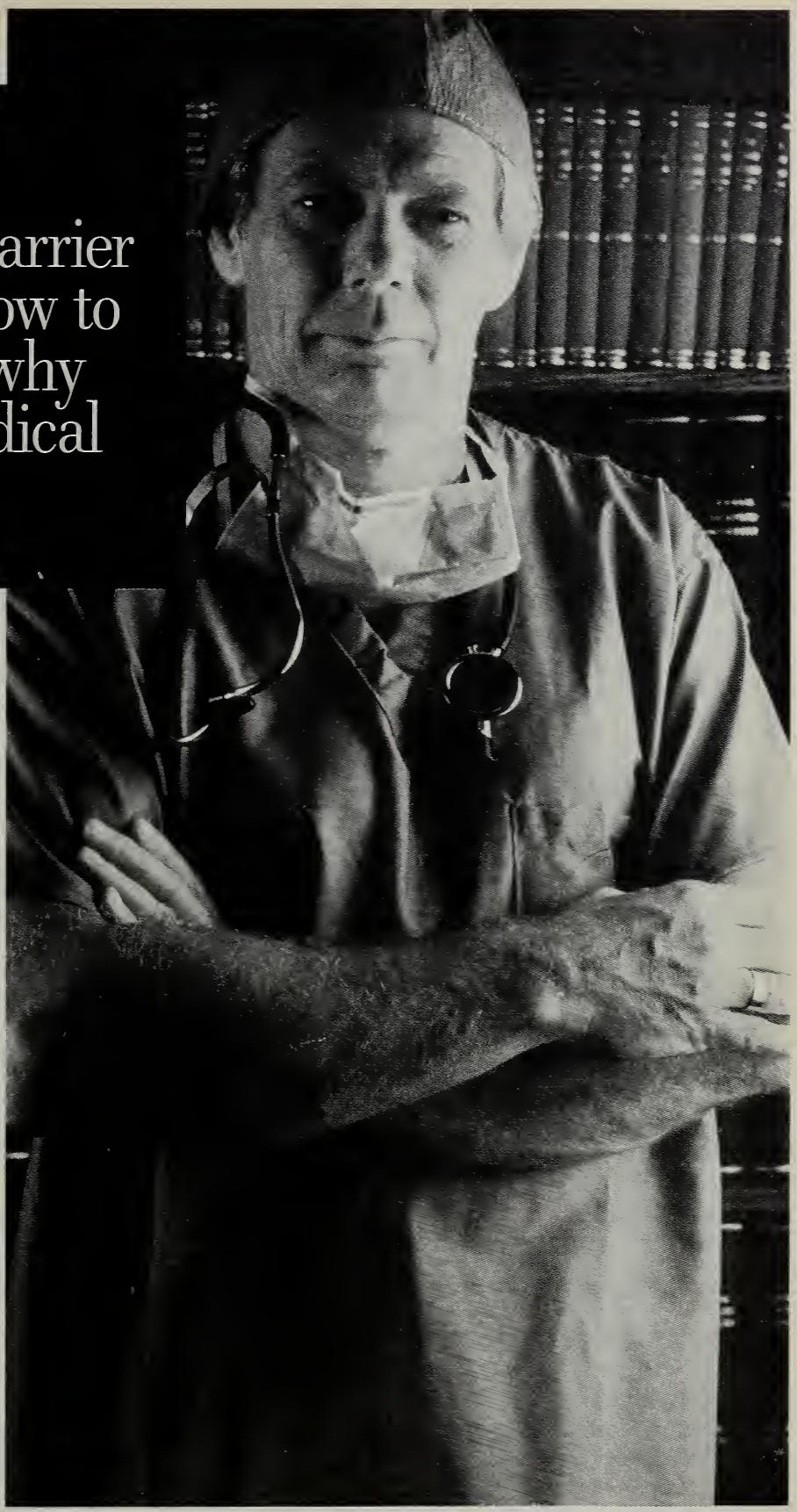
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New AFMC Committees Developed

Don G. Howard, M.D.*

At the November 1989 Board of Directors meeting, administrative committees were established as recommended by the Committee on Committees. The Committee on Committees has been established to review the organization and recommend appropriate committees to the AFMC board. The committees are not responsible for implementing action, but will act as advisory bodies to the board of directors. The chairman of the board of directors, chief executive officer, and executive vice president for Medical Affairs shall act as ex-officio members of each committee.

The new committees and their functions are as follows:

New Business/New Contract Committee

This committee will review and approve any request for proposal or proposed business expansion representing a new line of business, whether federal, state, or private, prior to the actual planning/writing of the bid/proposal by the AFMC staff. The committee's approval must be ratified by a majority of the AFMC board of directors at its next regularly scheduled meeting. Modifications of existing contracts are to be provided to the committee members for informational purposes in the form of an executive summary.

Committee members are:

Morton C. Wilson, M.D., Fort Smith - Chairman
Asa A. Crow, M.D., Paragould
W. Ray Jouett, M.D., Little Rock
Mr. Earl Eddins, Fayetteville
John P. "Jack" Burge, M.D., Lake Village

Credentials Committee

This committee will recommend appointment of all physician advisors (and to recommend reappointment of all physician advisors every two years) and recommend appointment or reappointment of all professional review committee members. The Credentials Committee must evaluate: AFMC profile of the physician advisor applicant; license verification; hospital staff status; physician advisor application, which is to include specifics of practice, number of patients seen per week, hours of CME per year, and committee appointments; appraisal by the executive vice president for Medical Affairs/Medical Director; and, activity of practitioner in his/her field. The committee's decisions must be ratified by a majority of the board at its next meeting.

Committee members are:

Richard N. Pearson, M.D., Rogers - Chairman
John C. Henderson, M.D., Searcy
Carl E. Northcutt, M.D., Stuttgart
George V. Roberson, M.D., Pine Bluff
James E. Zini, D.O., Mountain View
Joe H. Stallings Jr., M.D., Jonesboro
Charles A. Ledbetter, M.D., Harrison

Finance Committee

This committee will review the annual budget, receive and act upon the quarterly financial reports. The committee must have an independent audit performed by a CPA firm chosen by the committee on an annual basis paid for by the AFMC. The committee must be informed of all expenditures, including travel, for sums equal to or greater than $2,500 and less than $10,000. All expenditures in excess of $10,000 must have prior approval by the Finance Committee. No reserve fund transfers may be made without the prior approval of the treasurer. Annual salary increases for management personnel must be approved prior to the anniversary of employment. Actions of the committee must be ratified by a majority of the AFMC board of directors.

Committee members are:

Don G. Howard, M.D., Fordyce - Chairman
Jerry R. Kendall, M.D., Camden
Arthur E. Squire Jr., M.D., Little Rock
James R. Weber, M.D., Jacksonville
James M. Kolb Jr., M.D., Russellville
Ms. Stella Bucknam, CFO, AFMC, Fort Smith

Liaison and Public Relations Committee

This committee will act as advisors to the AFMC staff regarding AFMC publications (***Update*** to hospitals, ***Newsletter*** to physicians, monthly information to the board of directors) and establish liaison with any group representing health care providers and practitioners.

Committee members are:

Richard N. Pearson, M.D., Rogers - Chairman
Charles F. Wilkins Jr., M.D., Russellville
Donald B. Baker, M.D., Fayetteville
James L. Maupin, M.D., Dardanelle
James L. Gardner, M.D., Hot Springs
Robert R. Sykes, M.D., Nashville
Oliver Wallace, M.D., Green Forest

* Dr. Howard is chairman, Committee on Committees for the Arkansas Foundation for Medical Care, Inc., Fort Smith, AR.

Personnel Committee

This committee will serve as a search and recommendation committee for all management level members of the AFMC staff and any staff member with a salary of $35,000 or greater. The committee must make recommendations to the AFMC board of directors prior to appointment of the above.

Committee members are:

James D. Armstrong, M.D., Ashdown - Chairman
Joe V. Jones, M.D., Blytheville
Rhys A. Williams, M.D., Harrison
L.J. Patrick Bell, M.D., Helena
Mr. Robert Dougherty, Russellville
Mike Moody, M.D., Salem

Bylaws Committee

These committee members are to be knowledgeable of bylaws, philosophy, and policy of the Arkansas Foundation for Medical Care. The committee shall draft statements of philosophy and policy and amendments to the bylaws for the recommendation to the board of directors and to the general membership. The committee shall review the bylaws, philosophy, and/or policy to assure that the reciprocal changes are made to guarantee continuity. The committee shall review action of the board of directors and general membership to determine whether the action is a conflict with established bylaws, philosophy, and/or policy.

Committee members are:

James R. Weber, M.D., Jacksonville - Chairman
Don G. Howard, M.D., Fordyce
Asa A. Crow, M.D., Paragould
Judge Robert Hays Williams, Russellville
Robert H. Langston, M.D., Harrison
Robert W. Barnes, M.D., Little Rock

Ten Commandments of Peer Review

1. Thou shalt not use vague language or personal references in describing review.
2. Thou shalt not use strong, irritative, or inflammatory words in review.
3. Thou shalt base all decisions upon facts available at time of care.
4. Thou shalt base no decisions solely upon outcome.
5. Thou shalt utilize dynamic community standards.
6. Thou shalt give benefit of doubt to the physician at the bedside.
7. Thou shalt recognize that medicine is not practiced as a perfect science.
8. Thou shalt match review to true peers whenever possible.
9. Thou shalt not review friends, enemies, or competitors.
10. Thou shalt not jump to a premature decision.

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Things To Come

March 24-29

Spring Meeting of the American Society of Clinical Pathologists. Presented and sponsored by ASCP/CAP. San Francisco Civic Auditorium, San Francisco, CA. CME credit available. For further information, call ASCP at 1 (800) 621-4142.

March 30-31

Contemporary Pediatrics for the Practicing Physicians. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact the Susan Gilson, University of Kentucky, (606) 233-5161.

March 30 - April 1

Pediatrics 1990. Presented by Elizabeth R. McAnarney, M.D. (Adolescence); Raymond V. Caputo, M.D., (Dermatology); Sarah S. Long, M.D. (Infectious Diseases); Avroy A. Fanaroff, M.D. (Neonatology); Michael J. Goldberg, M.D. (Sports Medicine). Sponsored by the American Academy of Pediatrics. Marco Island Hilton Hotel, Marco Island, FL. Sixteen Category I credit hours. Fees: $220, AAP Resident Fellow, Candidate Fellow and allied health professionals; $300, AAP Fellow; $365, nonmember physician. Further information call 1 (800) 433-9016 and ask for CME Registration.

April 5-6

17th Annual Symposium on Obstetrics and Gynecology. Presented and sponsored by the Washington University School of Medicine. Washington University Medical Center, St. Louis, MO. CME credit available. For further information contact, Cathy Caruso, CME, Washington University School of Medicine, 1 (800) 325-9862.

April 6-7

Aggressive Management of Diabetes and Obesity. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson, University of Kentucky, (606) 233-5161.

April 18-22

10th Annual National Pediatric Infectious Disease Seminar and Special Session on A Preventive Approach to Medical Malpractice. Sponsored by the Department of Pediatrics, Southwestern Medical Center, Dallas, TX. Hyatt Regency Hotel, New Orleans, LA. Twenty-one Category I credit hours available for the Symposium and Seminar; 3 Category I credit hours for the Special Session. Fees: $350, physicians; $250, residents, Fellows, PA's and PNP's. For further information call (214) 688-8845.

April 23-27

Physician in Management I & II. Sponsored by the American College of Physician Executives, Tampa, FL. Cottonwoods Resort, Scottsdale, AZ. CME credit available. For more information, call 1 (800) 562-8088.

April 27-28

Sports Medicine for Physicians. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson at (606) 233-5161.

May 2-5

Ambulatory Surgery '90: Focus on Excellence. Sponsored by the Federated Ambulatory Surgery Association. Anaheim Marriott. For further information, contact Gail Durant, (703) 836-8808.

May 16-19

The National Conference of Physician Executives. Sponsored by the American College of Physician Executives, Tampa, FL. Marriott Rivercenter, San Antonio, TX. CME credit available. For more information, call 1 (800) 562-8088.

May 19

Trauma Symposium. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington,KY. For further information contact Susan Gilson at (606) 233-5161.

May 20-26

21st Family Medicine Review - Session II. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson at (606) 233-5161.

May 25-27

Advances in Pediatrics. Presented by Catherine DeAngelis, M.D. (Ambulatory Pediatrics); Burton W. Fink, M.D. (Cardiology); Mark Sperling, M.D. (Endocrinology); Georges Peter, M.D. (Infectious Diseases); John E. Lewy, M.D. (Nephrology); Charles F. Weiss, M.D. (Course Monitor). Sponsored by the American Academy

of Pediatrics. Hilton Head Island, South Carolina. Sixteen Category I credit hours. Fees: $220, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016 and ask for CME Registration.

June 1-2

3rd Annual Contact Lens Course. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 6-9

Facial Rejuvenation. Sponsored by the Washington University School of Medicine, St. Louis, MO. Ritz-Carlton St. Louis Hotel. CME credit available. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 6-10

7th Annual Meeting of the Southern Orthopaedic Association. Sponsored by the Southern Orthopaedic Association, Birmingham, AL. Hyatt Regency Hotel, Maui, Hawaii. CME credit to be announced. For further information, contact Jeanette Stone at (205) 945-1848.

June 7-9

Frontiers in Endosurgery: Flexible Endoscopy, Laser Surgery and Endourological Techniques. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. FOR UROLOGISTS ONLY. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 11-15

Physician in Management I & II. Sponsored by the American College for Physician Executives, Tampa, FL. Four Seasons Hotel, Philadelphia, PA. CME credit available. For more information, call 1 (800) 562-8088.

June 22-24

Clinical Pediatrics. Presented by Richard J. Summers, M.D. (Allergy); Barton D. Schmitt, M.D. (Behavioral Pediatrics); Sidney Hurwitz, M.D. (Dermatology); William F. Balistreri, M.D. (Gastroenterology); Ellen R. Wald, M.D. (Infectious Diseases); R. James McKay Jr., M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Washington, D.C. Fees: $200, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016.

Physician's Recognition Award

The Physician's Recognition Award is awarded each year to physicians who have completed acceptable programs of continuing medical education. This year's recipients are:

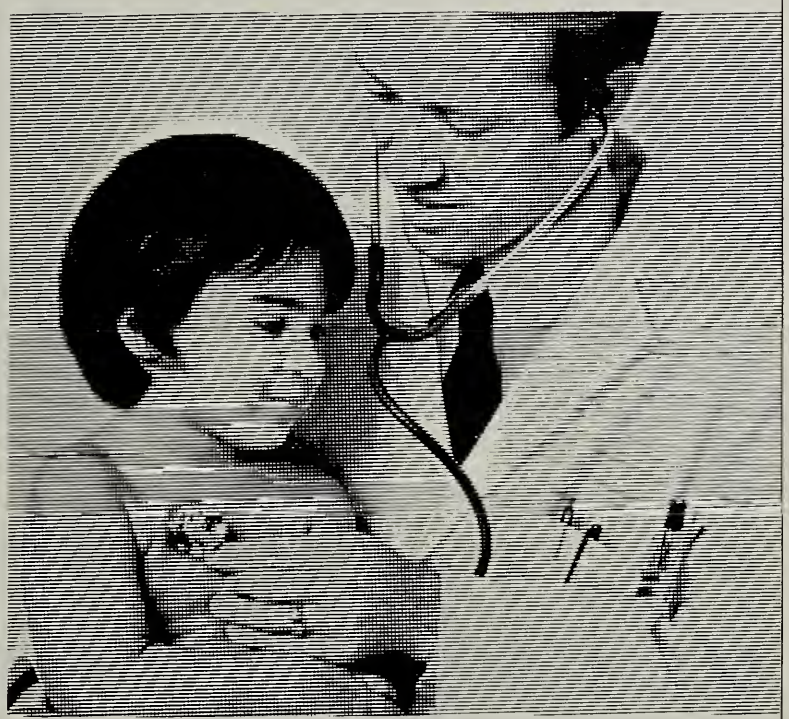
Jacob Amir, Little Rock
Junius B. Cross, Little Rock
Demetrio M. Hechanova, Hot Springs
Stephen Frank Kemp, Little Rock
Thomas Roland Koehler, Little Rock
Stephen Charles Manus, Fort Smith
James Ralph McCoy, Searcy
David Bryan Rhodes, Jacksonville
David Larry Staggs, Searcy
David Lewis Stewart, Benton

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Keeping Up

Third Annual AIDS Seminar

March 17, times to be announced. Sponsored by the AMS Committee on AIDS. Hot Springs Hilton Hotel, Hot Springs. Program to include general session, concurrent sessions and luncheon speaker. CME credit pending.

25th Annual Surgical Symposium

March 23-24, times to be announced. Presented by Robert Barnes, M.D. Sponsored by UAMS College of Medicine. Hot Springs. Fees and CME credit hours to be announced.

The Hot Springs Regional Perinatal Conference

March 30-31, 7:30 a.m. - 11:50 a.m. Sponsored by the Arkansas High Risk Pregnancy Program and the University of Arkansas for Medical Sciences Department of Continuing Education for Physicians. Lake Hamilton Resort and Conference Centre, Hot Springs. Seven Category I credit hours. Fees: Physicians, $50; Nurses and other professionals, $35; Full-time students and residents, $20 ; Guests, $15.

Cardiovascular Conclave 1990

April 7, times to be announced. Presented by the Arkansas Cardiovascular Surgery Associates, P.A. Sponsored by Baptist Medical Center, Little Rock. University Conference Center, Little Rock. Five Category I credit hours. No Fee. For further information, contact Patricia Pollack, 224-5666.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon for Medical/Dental Staff, varying topics, alternating Fridays, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Alternating Sub-Specialty Conference, third Wednesday, 1:30 p.m., Second Floor Classroom
Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Building Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuropsychiatry Conference, second Wednesday, 1:30 p.m., Second Floor Classroom
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., Second Floor Classroom
Pediatric Pathology Conference, first Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, Second Floor Classroom
Pediatric Radiology Conference, first Thursday, 12:00 noon, Sturgis Auditorium
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom
Problem Case Conference, Fridays, 12:00 noon, Second Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

CARTI Tumor Conference, first Wednesday, 12:00 noon, CARTI Auditorium. Lunch is served.
Cancer Conference, third and fourth Thursday, 12:00 noon, Southwestern Bell/Arkla Rooms. A meal is provided.

Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. Sandwich buffet served.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
General Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. Lunch is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Surgery Journal Club, Mondays, 12:00 noon, Operating Room Conference Room (2 Northwest). Sandwich buffet served.
Interdisciplinary AIDS Conferernce, second Friday, 12:00 noon, LaHarpe Room. Sandwich buffet is served.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Conference Room 1. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Peripheral Vascular Disease, fourth Tuesday, 6:00 p.m., J. A. Gilbreath Conference Center, Room 8.
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Rom G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08

Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
Urology Morbidity and Mortality Conference, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernard's Annex Building
Arkansas Methodist Hospital CME Conference, last Friday, 7:00 a.m., Arkansas Methodist Hospital, Paragould
Cherokee Village Tumor Conference, third Monday, every four months, 6:00 p.m., Ozark Baptist Memorial Hospital, Cherokee Village
Chest Conference, fourth Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room
Independence County Medical Society, second Tuesday, 7:30 p.m., White River Medical Center, Batesville
Interesting Case Conference, second and fifth Tuesday, when applicable, 12:00 noon, St. Bernard's Dietary Conference Room
Kennett Tumor Conference, second Tuesday (every other month), 12:00 noon, Twin Rivers Regional Medical Center, Kennett, MO
Methodist Hospital of Jonesboro CME Staff Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Monthly Medical Lecture Series, third Tuesday, 7:30 p.m., rotates each month between Walnut Ridge and Pocahontas
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, second Friday, 12:00 noon, St. Bernard's Dietary Conference Room
Newport Tumor Conference, second Wednesday, 12:00 noon, rotates each month between Harris Clinic and Newport Hospital
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room
Piggott Tumor Conference, third Wednesday, 12:00 noon, Piggott Hospital, every four months.
Poplar Bluff Tumor Conference, third Wednesday, 12:00 noon, Lucy Lee Hospital, Poplar Bluff
Tumor Conference, fourth Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center

Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital

Medicine in the News

CPR Mannequin Donated to AMS

The Arkansas Medical Society received a high-tech mannequin, commonly referred to as "Resusci-Anne", as a gift from the National Automobile Dealer's Charitable Foudation (NADCF) and the Arkansas Automobile Dealer's Association (AADA). The presentation was the focus of a recent news conference held at the AMS office.

The gift is the 20th unit donated to the state's health and education groups for training the correct techniques used in cardio-pulmonary resuscitation (CPR). The mannequin will be utilized to help train and certify medical students to become CPR instructors, who in turn can use their skills to teach in their communities.

The AADA is the only organization that provides "Resusci-Anne's" to groups upon request, whereas the mannequins would normally have to be borrowed or rented.

It is estimated that over 25,000 Arkansans have been instructed on these mannequins. Since CPR training has been receiving national attention, the number of victims saved by this treatment has increased dramatically.



AMS Receives CPR Mannequin: (from left) Ken LaMastus, AMS Executive Vice President; Victor Chu, med student; Evelyn Cathcart, med student; Jeff Craig, med student; Rich Payne, med student; Sherilyn Webb, instructor; Carla Scott, instructor; David Wroten, AMS Assistant Executive Vice President; and Jay Menna, Ph.D., Assistant Dean for Medical Education.

A Change of Hands

The ***Family Practice Research Journal*** is now an official journal of the American Academy of Family Physicians (AAFP), signifying the Academy's efforts to support clinical research by family physicians.

Currently published twice a year, the journal will become a quarterly publication beginning with the June 1990 issue.

Regular Mammograms Save Lives

Breast cancer was detected early in 27 women who took the time to have a mammogram in the American Cancer Society's 1989 Arkansas Breast Screening Project.

Dr. Robert Elliott, state chairman of the project, said 7,543 Arkansas women took advantage of the discounted screening mammograms.

"Twenty-seven cancers were found. But because the cancers were detected in their early stages, all 27 were treatable and their prognoses are good."

Last year 350 Arkansas women died from breast cancer out of 1,110 who were diagnosed with the disease.

The Arkansas Division of the American Cancer Society promoted the Arkansas Breast Screening Project last April to stress a three-part cancer defense that includes monthly breast self-examination, examination by a physician and regular mammograms for women over the age of 35.

"This program was very successful," Dr. Elliott said. "This was our second year to conduct the Arkansas Breast Screening Project and the number of calls received from Arkansas women wanting information on the early detection of breast cancer increased by nearly 3,500. That's a real indication women want and need this type of program, and I'm sure if you asked each of those 27 women who were detected with breast cancer, they'd tell you the same thing."

Including all three phases of the program, more that 87,000 Arkansas women were reached with the breast health awareness program during the campaign.

Arkansas Lions Eye & Kidney Bank Certified

The Arkansas Lions Eye & Kidney Bank in Little Rock was recently granted certification by the Eye Bank Association of America (EBAA), EBAA chairman Richard L. Fuller announced from the association's Washington, D.C. headquarters.

The certification follows an intensive on-site review of the eye bank's facilities by trained representatives of the Medical Standards Committee of the EBAA. The process includes an evaluation of the eye bank technical policies and procedures based on the EBAA's vigorous Medical Standards, the first such criteria developed by a national transplant organization and the eye banking standards approved by the American Academy of Ophthalmology.

To ensure patient safety, the EBAA's strict medical standards mandate the thorough screening of the donor's medical history and evaluation of the donated eye tissue. Eye banks must meet EBAA recertification standards every three years.

"Certification confirms that the eye and kidney bank meets or exceeds the rigid technical standards agreed upon by the medical community to maintain high levels of quality and efficiency in the eye bank's operations," Fuller said.

"The EBAA is proud of the Arkansas Lions Eye & Kidney Bank's performance and leadership roles in eye donation, corneal transplantation, and research."

There were a record 83,758 eye donations in North America in 1988. More than 36,900 of these were used for sight-restoring transplant surgery.

AMA Legislative Update

Legislative and regulatory activities centered upon Physician Reimbursement Reform and Resource Based Relative Value Scale implementation have been identified by the AMA as one of 16 areas of professional concern that it believes will require maximum or major involvement by the Association and the Federation during the Second Session of the 101st Congress. Key elements tied to this reimbursement reform will be Medical Volume Performance Standards (MVPS), "overpriced" procedures, MAACs and mandated assignment. In thoroughly assessing the current national legislative environment, AMA concluded these additional legislative and regulatory issues also likely will command the profession's greatest attention in 1990:

Quality of Care:
* Practice Parameters
* Volume/Utilization
* PRO/Utilization Review

Strengthening the Health Care System:
* Covering the Uninsured & Underinsured
* Mandated Health Insurance Coverage
* Expansion of Medicaid
* Long Term Care Coverage

Substance Abuse:
* Alcohol, Tobacco and Drugs

Professional Liability
Unrelated Business Income Tax
AIDS

Promulgating Regulations On:
* Physician Referral
* Clinical Laboratory Requirements/Procedures

AMA believes six other areas of professional interest will require lesser, but nevertheless major, attention in the Federation's 1990 legislative activities. They are:

Medicare Reform
Budget Deficit & Reconciliation (support for)
* Biomedical Research, NIH, Graduate Medical School

Animal Welfare
Campaign Financing
Anti-Trust
Adolescent Health

Major Technical Advances Create Billions For CNS Drugs

The explosion of small start-up companies hoping to develop new agents to fill the gaps in our current central nervous system (CNS) drug arsenal is leading to countless

opportunities for pharmaceutical, chemical, biotechnology, and biomedical companies. These opportunities range from licensing the rights to patented processes, to collaborating in research, to entering into marketing agreements. Both the opportunities and the technical challenges presented by this avalanche of scientific advances are explored in a new report entitled, ***Neurobiology: Exploiting Advances in the Next Biomedical Frontier***, published by Technical Insights, Inc., of New Jersey.

According to Technical Insights, the market for drugs targeted at the central nervous system is $1 billion in the United States alone, and $3 billion worldwide. And, with the scientific advances being made almost daily, by the year 2000, this market is projected to grow to $7.6 billion in the United States, and three times that amount worldwide.

For more information on ***Neurobiology: Exploiting Advances in the Next Biomedical Frontier***, contact Technical Insights, Inc., PO Box 1304, Fort Lee, NJ 07024-9967.

An AMA Victory

Based in part on the AMA's efforts, Congress has established a new procedure for notifying beneficiaries of a PRO's determination to disapprove coverage for health care services or items in instances where the quality of services fail to meet professionally recognized standards of health care (the previously established "quality standard"). A PRO will not inform a beneficiary that services failed to meet the quality standard until:

* the PRO has notified the provider or practitioner of the determination and of the right to a formal reconsideration;
* the reconsideration, if requested, has been completed.

This new procedure significantly expands physicians' due process rights by providing the opportunity for a formal reconsideration for quality of care issues prior to beneficiary notification. Note however, that adverse PRO determinations not involving the quality of care standards remain subject to the prior rule, under which beneficiaries receive notification prior to a formal reconsideration. The new procedure does not affect beneficiaries' reconsideration rights.

If a PRO determines that health care services or items fail to meet the quality of care standard, the notice to the beneficiary will state: "In the judgement of the PRO, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician and hospital".

This procedure will apply to PRO determinations in which preliminary notifications were made more that 30 days after enactment; this rule was enacted December 18, 1989.

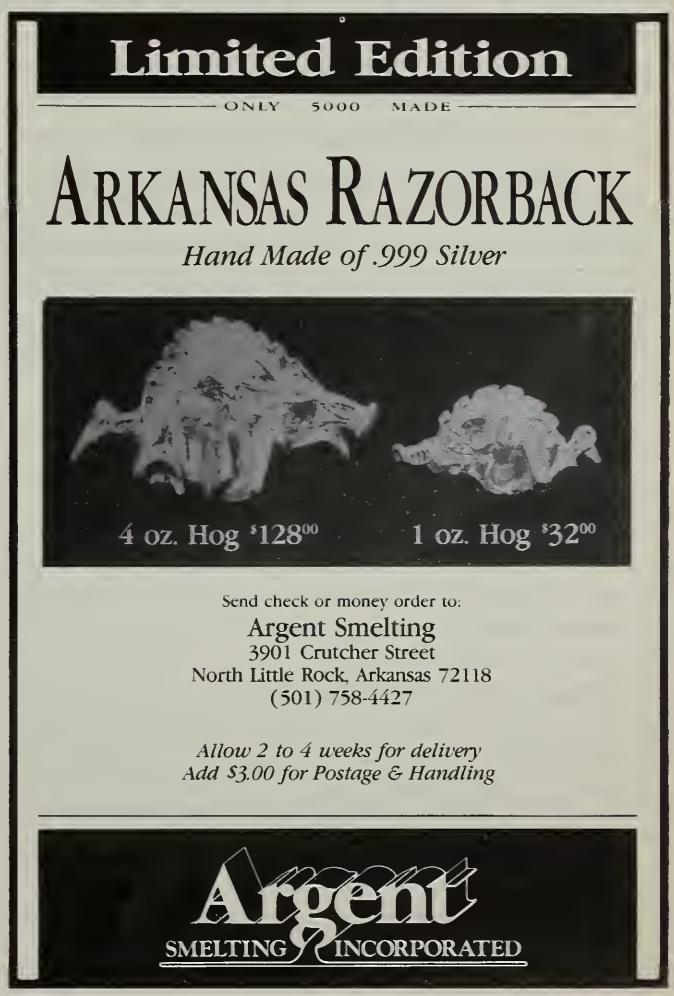
The Arkansas Health Care Access Foundation Helps 830

The Arkansas Health Care Access Foundation, a statewide network of volunteer health care providers, has provided free medical services to 830 medically indigent persons since the programs inception in mid-September.

Over 3,000 Arkansans who do not qualify for Medicaid and do not have private insurance have been certified for eligibility.

The program initiated by the Arkansas Medical Society, has 1,552 volunteer health care providers including medical doctors, home health agencies, and pharmacists. These providers have rendered free treatment in 65 of the 75 Arkansas counties.





AMS NewsMakers

Rhys A. Williams, M.D., of Harrison, has been reappointed to the Arkansas State Medical Board by Governor Bill Clinton. The term will expire December 31, 1997.

Don B. Vollman Jr., M.D., a Jonesboro pathologist, has been elected unanimously to serve as president of the State Board of Health. Dr. Vollman has also been elected to the board of directors of Simmons First Bank of Jonesboro.

Tom Wortham, M.D., of Jacksonville, has been elected president of the Rebsamen Regional Medical Center Development Foundation.

Ray H. Hall Jr., M.D., of Jonesboro, has been elected a fellow of the American College of Physicians. Dr. Hall is currently president of the Craighead-Poinsett Medical Society.

William R. McKiever, M.D., of Monticello, has been chosen a member of the Arkansas Academy of Family Physicians.

Ronald T. Plott, M.D., a dermatology intern at the University of Arkansas for Medical Sciences, has won first place in the 1989 Young Investigator Competition of the American Society for Dermatologic Surgery.

Walter G. Klugh, Jr., M.D., of Hot Springs, recently retired from St. Joseph's Hospital. Dr. Klugh joined the staff of St. Joseph's in 1956, and has served as director of anesthesia since that time. He founded the respiratory therapy department and served as its director for several years, was chief of staff in 1980, and is past president of the Garland County Medical Society.

New Members

CRAIGHEAD COUNTY

Nash, Jerry D., Neurology, Jonesboro. Born December 30, 1953, Jackson, MS. Pre-medical education, University of Texas, Austin, TX, 1980. Medical education, Baylor College of Medicine, Houston, TX, 1985. Internship/residency, University of Texas Medical Branch, Galveston, TX 1989. Board eligible. Member, American Academy of Neurology.

CRAWFORD COUTNY

Suthoff, James L., Anesthesiology, Van Buren. Born November 21, 1954, St. Thomas, MO. Pre-medical education, University of Missouri, Columbia, MO, 1976. Medical Education, Kirksville College of Medicine, Kirksville, MO, 1985. Internship, Charles E. Still Osteopathic Hospital, Jefferson City, MO, 1986. Residency, Botsford General Hospital, Farmington Hills, MI, 1989. Certification pending. Member, American Society of Anesthesiologist.

FAULKNER COUNTY

Bowlin, Randal G., Family Practice, Conway. Born June 28, 1958, Minden, LA. Pre-medical education, University of Central Arkansas, Conway, AR, 1981. Medical education, University of Arkansas Medical School, Little Rock, AR, 1986. Internship/residency, Family Practice, Fort Smith, AR, 1989. Board certified. Member, American Association of Family Practioners.

INDEPENDENCE COUNTY

Garst, Neeva, Family Practice. Born June 5, 1952, India. Medical education, Christian Medical College, Ludiana Punjab, India, 1976. Internship/residency, University of Arkansas Medical for Sciences, Little Rock, AR, 1981. Practice experience, 8 years. Board certified. Member, Arkansas Academy of Family Physicians.

Piediscalzi, N.J., General Practice. Born July 5, 1939, Chicago, IL. Pre-medical education, Loyola University, 1964; Southern Illinois University, 1967. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1977. Internship, UAMS, Little Rock, AR, 1978. Practice experience, 11 years. Appointments, Director of Laboratory; Head-Infectious Diseases; Chief of Staff, Stone County Medical Center.

* These people were inadvertantly placed in the Pulaski County section in the February issue.

JEFFERSON COUNTY

Bennett, John M., Family Practice, Pine Bluff. Born May 18, 1958, Stillwater, OK. Pre-medical education, Arkansas State University, Jonesboro, AR, 1981. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1986. Internship/residency, AHEC South Arkansas, El Dorado, AR , 1989. Board certified. Member, ABFP, AAFP, Arkansas AFP.

Rayford, Cleveland E., Internal Medicine, Pine Bluff. Born September 29, 1955, Pine Bluff, AR. Pre-medical education, University of Arkansas at Pine Bluff, Pine Bluff, AR, 1977. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1982. Internship/residency , University of Missouri, Kansas City, MO, 1985. Practice experience, 4 years. Member, American Society of Internal Medicine.

MILLER COUNTY

Hodson, Gregory R., Cardiovascular-Thoracic, Texarkana, TX. Born November 30, 1952, Salt Lake City, UT. Pre-medical, University of Utah, 1978. Medical education, University of Utah School of Medicine, Salt Lake City, UT, 1982. Internship/residency, University of Iowa; University of Utah, 1989. Board certified.

SEBASTIAN COUNTY*

Asche, Chris V., Gastroenterology/Internal Medicine, Fort Smith. Born March 24, 1949, Tempe, AZ. Medical education, University of Arkansas Medical Sciences, Little Rock, AR, 1979. Internship/residency, Brooke Army Medical Center, Ft. Hood, TX, 1982. Practice experience, 7 years. Board certified. Member, American Gastroenterologic Association, American Society for GI Endoscopy.

Christopher-Harmon, Pamela J., Family Practice, Fort Smith. Born, August 6, 1954, Memphis, TN. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1985. Internship/residency, AHEC, Fort Smith, AR, 1988. Member, AAFP.

Daily, Richard E., Aubulatory Care, Fort Smith. Born April 23, 1952, Mulberry, AR. Medical education, University of Arkansas School of Medicine, Little Rock, AR, 1979. Internship, Baptist Medical Center, Little Rock, AR. Practice experience, 10 years.

Heim, Stephen A., Orthopaedics, Fort Smith. Born May 15, 1956. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1983. Internship/residency, UAMS, 1988.

Marvin, Michael E., OB/GYN, Fort Smith. Born Feruary 10, 1950, Fort Smith, AR. Medical education, University of Oklahoma, Oklahoma City, OK, 1984. Residency, Scott & White, Temple, TX, 1988. Board eligible.

Rosenzweig, Kenneth M., Orthopedic Surgery, Fort Smith. Born July 31, 1955, New Orleans, LA. Medical education, University of Arkansas for Medical Sciences, Little Rock, AR, 1982. Internship/residency, UAMS, 1988. Board eligible.

Schwarz, Julio M., Group Practice in Cardiology, Fort Smith. Born April 28, 1951, Guatemala City, Guatemala. Medical education, University of San Carlos, Guatemala, 1975. Internship/residency, Mt. Sinai Medical Center/Case Western Reserve University, Cleveland, OH. Fellowship, Cardiology. Board eligible. Member, AMA, ACC.

SALINE COUNTY

Smith, Robert E., Radiology, Benton. Born June 27, 1956, Little Rock, AR. Pre-medical education, University of Texas, Austin, TX, 1978. Medical education, Southwestern Medical School, Dallas, TX, 1982. Internship, Tulane University Affiliated Hospitals, 1983. Residency, Michigan State University, Affiliated Hospitals, 1986. Practice experience, 3 years. Board certified.

STUDENT SECTION

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Resolution

Alvin W. Strauss Jr., M.D.

Whereas, the membership of the Pulaski County Medical Society are saddened by the recent death of their esteemed colleague, Alvin W. Strauss Jr., M.D.; and
Whereas, Dr. Strauss was a loyal member of this Society for over forty-five years; and
Whereas, his compassion and concern for the welfare of his patients was widely known; and
Whereas, Dr. Strauss' many contributions towards the betterment of his profession, including serving as president of the Arkansas Academy of Family Physicians, will be long remembered.

RESOLVED, that this resolution be included in the archives of this Society; and
RESOLVED, that a copy of this resolution be sent to Dr. Strauss' family as a token of our sincere sympathy; and
RESOLVED, that a copy be sent to the Journal of the Arkansas Medical Society for publication.

Adopted
Executive Committee
January 17, 1990

By Order of the Memorials Committee
Marlon Doucet, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

Memorials honoring Arkansas Medical Society members and their spouses can be made to the Medical Education Foundation for Arkansas (MEFFA), P.O. Box 5776, Little Rock, AR 72215. Call the Society for more information.

TAKE THE FIRST STEP TO RECOVERY

The Physicians Health Committee exists for you, the physician who is struggling with drug and/or alcohol addiction. The committee is composed primarily of physicians who have "been there" and only want to help their colleagues from making the same mistakes.

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All inquiries are confidential within the committee and no names or locations are necessary when contacting the Society office.

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The first page should list titles, degrees, and any hospital or university appointments of the author(s). Manuscripts should be typewritten, double-spaced, and have generous margins. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

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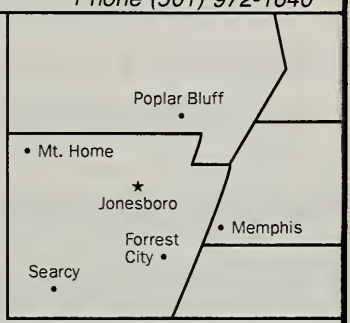
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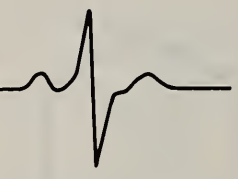
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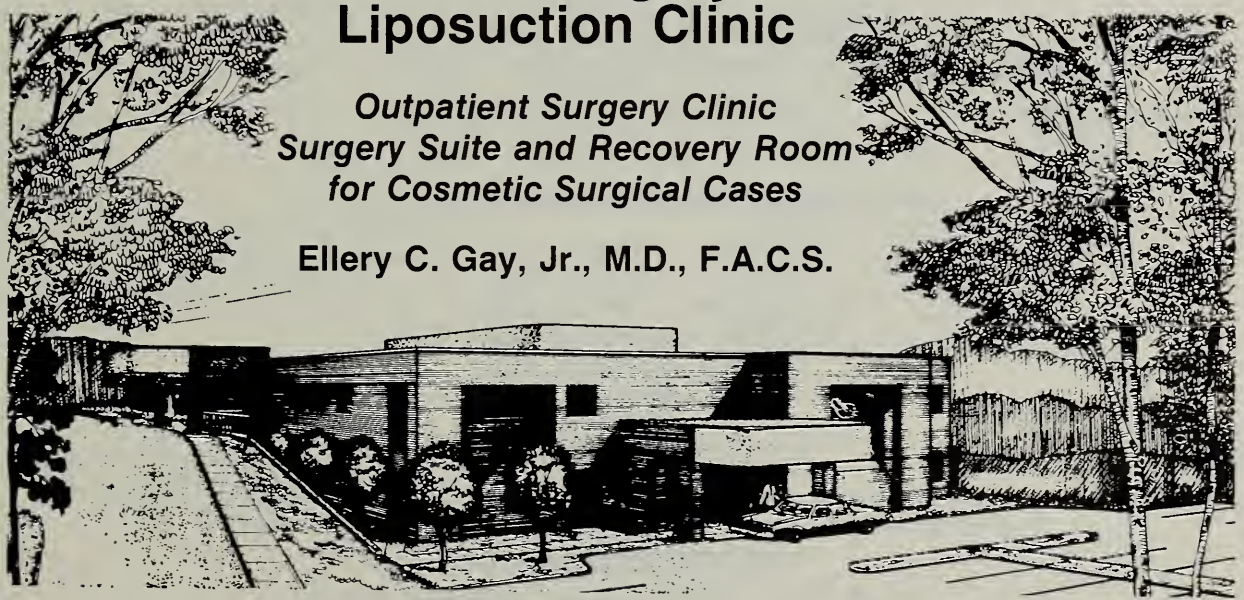
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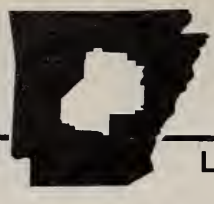
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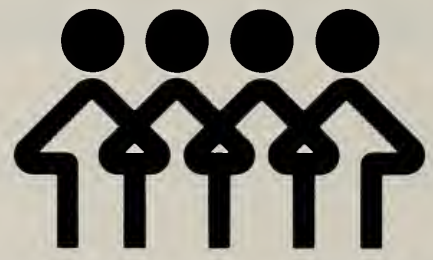
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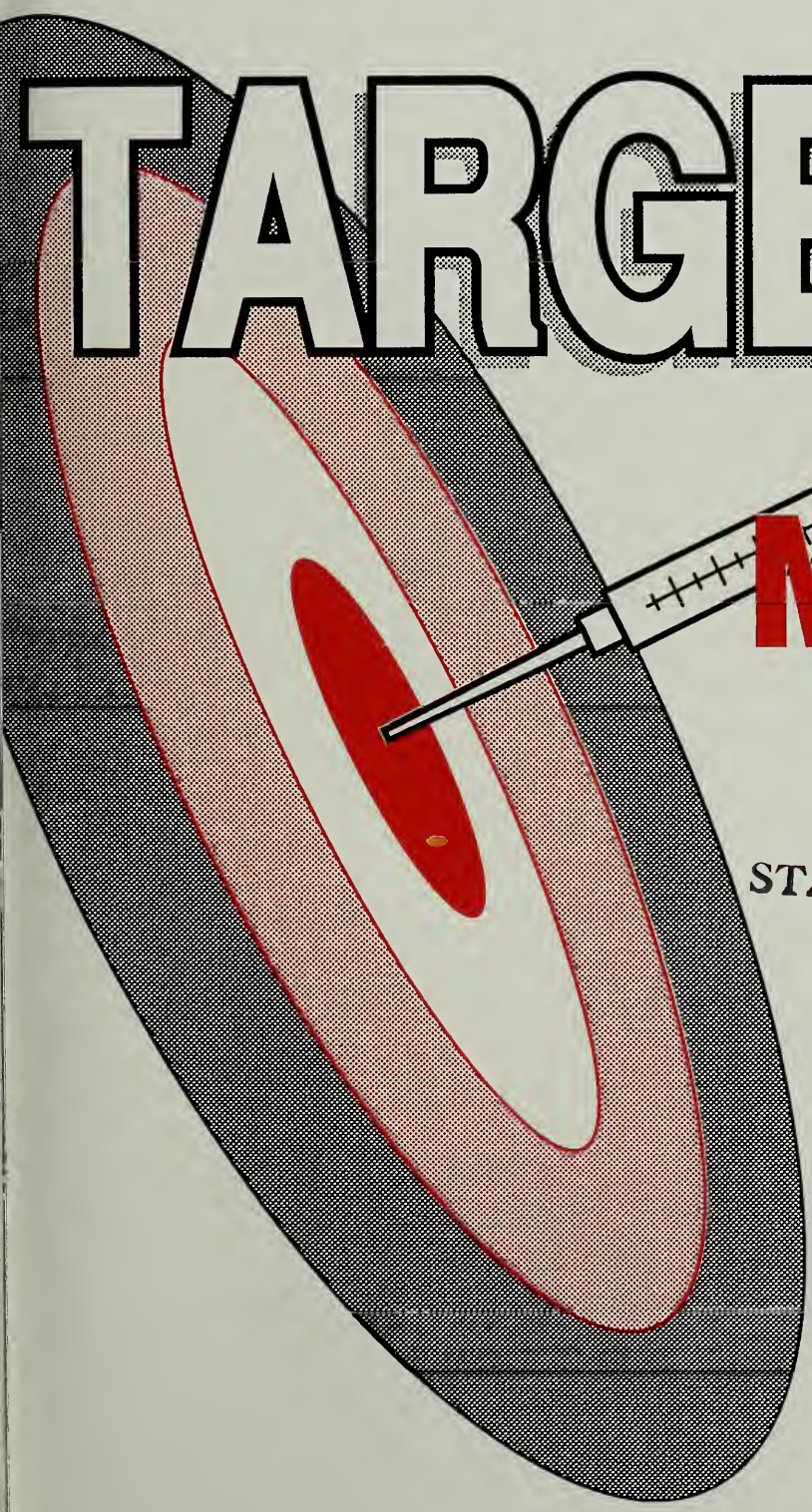
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Volume 86 Number 11 April, 1990

TARGETING MEDICINE IN THE 90's

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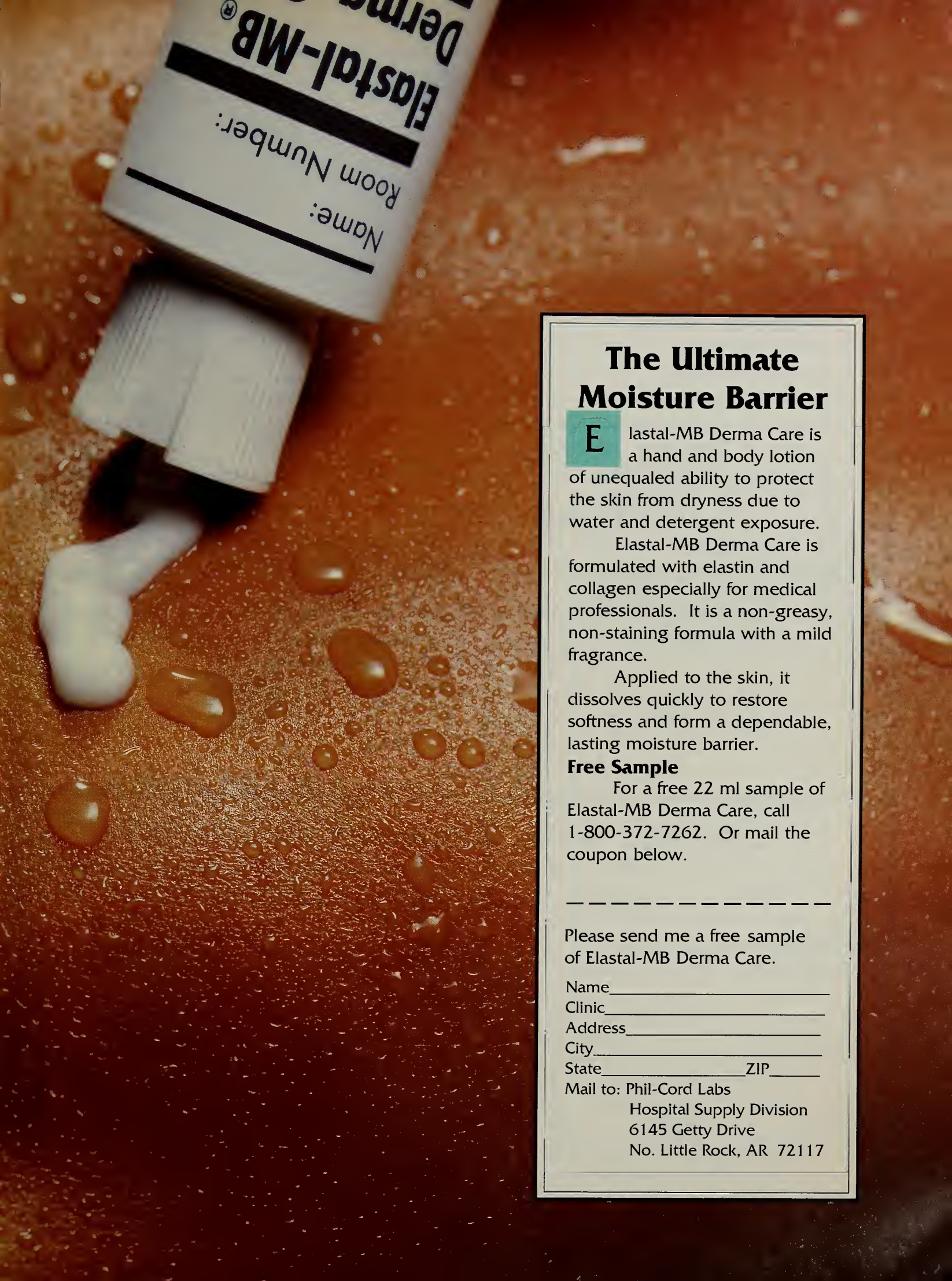
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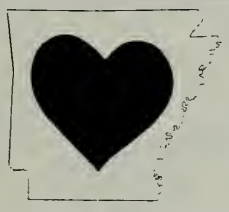
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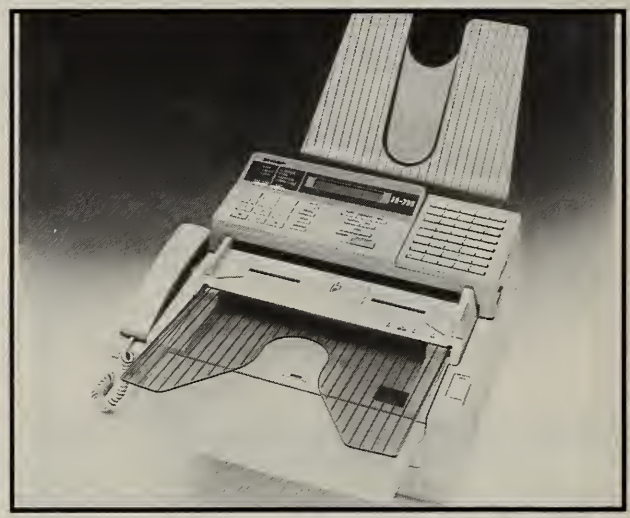
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114th Annual Session

May 3 - 5, 1990
Arlington Hotel and Exhibit Center
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Thursday, May 3, 1990

10:00 a.m.

Golf and Tennis Tournaments

Hot Springs Country Club - Participants must pre-register.

1:00 p.m. - 5:00 p.m.

Registration

Mezzanine

3:30 p.m. - 4:45 p.m.

Council Meeting

Venus Room

5:00 p.m. - 6:30 p.m.

House of Delegates

Conference Center B.
Keynote address:
Robert E. McAfee, M.D.
Trustee, AMA, Portland, Maine.



Robert E. McAfee, M.D.

7:00 p.m.

President's Reception and Silent Auction

Ballroom - Honoring 1989-90 President James R. Weber
The AMS Auxiliary will host a silent auction in conjunction with the reception. All proceeds will go to the AMA-ERF Fund.

Friday, May 4, 1990

7:30 a.m. - 5:00 p.m.

Registration

Mezzanine

7:30 a.m. - 9:00 a.m.

Continental Breakfast

Exibit Center - Exhibit Area Open

9:00 a.m. - 10:30 a.m.

First Feature Session

Conference Center B.
"Taking Aim at Doctors - The Trauma of a HCFA Sanction", Michael L. Burditt, M.D., Victoria, Texas
Donald P. Wilcox, J.D., General Counsel, Texas Medical Association, Austin, Texas.



Michael Burditt, M.D.



Donald P. Wilcox

10:30 a.m. - 11:45 a.m.

Reference Committee Meetings

#1: Jupiter Room
#2: Mercury Room
#3: Conference Center B

12:00 noon - 1:30 p.m.

Shuffield Lecture and Luncheon

Ballroom - Recognition of Shuffield Award Winner.

"Population Profile for the 21st Century", Henry G. Cisneros, Former Mayor, San Antonio, Texas.



Henry Cisneros

1:30 p.m. - 3:00 p.m.

Exhibit Area Open

Exhibit Center - Delightful deserts.

3:00 p.m. - 4:00 p.m.

Second Feature Session

Conference Center B - "Missing the Mark on Patient Care - The Horrors of Third-Party Utilization Review." Featuring a Select Panel of Arkansas Physicians; Lynn Zeno, Moderator.

4:15 p.m.

Council Meeting

Venus Room

7:00 p.m. - 8:30 p.m.

Blue Cross Blue Shield Reception

Conference Center C

Saturday, May 5, 1990

7:30 a.m. - 5:00 p.m.

Registration Open

Mezzanine

7:30 a.m. - 8:30 a.m.

MED-PAC Breakfast

Mercury Room - A new program addition recognizing MED-PAC contributors.

8:30 a.m. - 10:15 a.m.

Exhibit Area Open

Exhibit Center

8:45 a.m. - 9:30 a.m.

Council Meeting

Venus Room

10:30 a.m. - 11:45 a.m.

Third Feature Session

Conference Center B.
"Oregon's Medicaid Program - An Effort at Access", Senator Bill Bradbury, Majority Leader, Oregon State Senate.



Sen. Bill Bradbury

12:00 p.m. - 1:30 p.m.

Exhibitor Luncheon and Grand Prize Drawing

Exhibit Center - Grand Prize: 3 nights and 4 days vacation to the Acapulco Plaza Hotel including round trip airfare from Little Rock to Acapulco. Donated by Tours and Travel, Russellville, AR. Must be taken before December 15th, 1990 excluding holidays. Must be present to win.

12:00 noon

Fifty Year Club Luncheon

Cafe II

1:30 p.m. - 3:30 p.m.

Specialty Meetings

Locations to be announced.

Alan Cazort Allergy Society of Arkansas

Arkansas Academy of Family Physicians - **Open to all specialties - begins at 1:00 p.m.** "Managing Diabetes in the '90's." 2 1/2 hours of CME credit available.

Arkansas Chapter of the American Academy of Otolaryngology - Head and Neck Surgery

Arkansas Chapter of the American College of Radiology

Arkansas Orthopaedic Society.

Arkansas Psychiatric Society

Arkansas Society of Plastic and Reconstructive Surgeons

Arkansas Urologic Society - begins at 11:00 a.m.

3:45 p.m.

Memorial Service

Conference Center B - Members of the AMS and Auxiliary who have died during the past year will be remembered.

4:15 p.m.

House of Delegates

Conference Center B.
Keynote address:
Joycelyn Elders, M.D.,
Director, Arkansas Department of Health.



Joycelyn Elders, M.D.

6:15 p.m.

Past Presidents' Reception

A private reception for AMS Past Presidents and their spouses, recognizing their service to medicine.

7:00 p.m.

Inaugural Banquet

Ballroom - William N. Jones, M.D., will be installed as the 1990-1991 President of the AMS.
Master of ceremonies:
James R. Weber, M.D.
1989-90 AMS President.
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Robert Henry

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Thursday, May 3	1:00 p.m. - 5:00 p.m.
Friday, May 4	7:30 a.m. - 5:00 p.m.
Saturday, May 5	7:30 a.m. - 5:00 p.m.

No person will be admitted to any activity of the annual session without first registering. Upon checking in at the convention registration desk, you will receive a convention program, your name badge, tickets for meals and social functions, and other convention material.

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All cancellations must be made in writing and received by April 25, 1990 to receive a refund. No refunds will be given after that date. All refunds, minus a $10 processing fee, will be mailed after the conference. No refunds will be given on site.

Exhibits

Commercial and scientific exhibits will be on display in the Arlington Exhibit Center. Dr. Glen Baker, chairman of the Convention Exhibits Subcommittee, urges all members and their guests to take the time to visit the displays. The exhibits are a part of the educational program of the convention and provide members with the latest information on progress in pharmaceutical research, developments in instruments and equipment, insurance, accounting systems, computers, investments, and other new products and services available. The exhibits represent an important contribution to the convention. You are urged to visit each booth and let the exhibitors know you appreciate their participation.

Exhibit Hours

Friday, May 4:	7:30 a.m. -	9:30 p.m.
	1:30 p.m. -	3:00 p.m.
Saturday, May 5:	8:30 a.m. -	10:15 a.m.
	12:00 a.m. -	1:30 p.m.

Other Meetings

Fifty Year Club Luncheon

The Society will host a luncheon for members of the Fifty Year Club at 12:00 noon, Saturday, May 5th, at the Arlington Hotel. The Fifty Year Club President is Henry V. Kirby, M.D., of Harrison. Physicians eligible for the Fifty Year Club this year are R. P. Anderson, Arkadelphia; Howard Armstrong, Little Rock; John D. Ashley, Jr., Newport; Robert H. Atkinson, Hot Springs; Walter M. Bond, Fayetteville; Joseph A. Buchman, Little Rock; James L. Dennis, Little Rock; David D. Fried, Mena; James H. Growdon, Little Rock; Marlin B. Hoge, Fort Smith; L. Gordon Holt, Little Rock; Alfred Kahn, Jr., Little Rock; Leeman H. King, Hot Springs; James B. Kittrell, Texarkana; F. Lamar McMillin, Sr., Little Rock; John H. Miller, Camden; Malcolm O. Peeler, Jonesboro; Andrew A. Pringos, Little Rock; Ben N. Saltzman, Little Rock; Francis E. Shearer, Alma; John B. Stewart, Fort Smith; and George H. Wright, Hope.

Past Presidents Reception

All past presidents and their spouses are cordially invited to a reception prior to the Inaugural Banquet Saturday, May 5th. This distinguised group of Society leaders will also return to the tradition of the "long gray line" during the inauguration ceremony at the banquet.

The **Arkansas State Medical Board** will meet at 9:00 a.m., Wednesday, Thursday and Friday, May 2-4, in the hotel.

The **Arkansas State Board of Health** will hold a luncheon meeting Friday, May 4th, at 12:00 noon, in the hotel.

Specialty Meetings

Alan Cazort Allergy Society of Arkansas will meet from 1:30 p.m. until 3:30 p.m., on Saturday, May 5th. "Environmental Allergy" will be discussed by Claudia Miller, M.D., Assistant Instructor, Allergy and Immunology, Department of Pediatrics, University of Texas Health Sciences Center, San Antonio, Texas.

Arkansas Academy of Family Physicians will meet from 1:00 p.m. until 3:30 p.m., Saturday, May 5th. "Managing Diabetes in the '90s" will be discussed by Ronald Robinson, M.D., Endocrinology, Fort Smith; Brian Tulloch, M.D., Endocrinology, San Antonio, Texas; and Linda Reyle, R.N., Certified Diabetes Educator, Baptist Memorial Hospital, Memphis, Tennessee.

This meeting will offer 2 1/2 hours of continuing medical education credit.

Arkansas Academy of Otolaryngology - Head and Neck Surgery will have a luncheon meeting beginning at 11:30 a.m. Panel discussions: 1) "Audiologic Diagnostic Testing," Mike Winston, Ph.D., Little Rock, moderator; 2) "Indoscopic Sinus Surgery," Mike Reese, M.D., Rogers, moderator; 3) "Sleep Apena," Robert N. McGrew, M.D., Little Rock, moderator; and 4) "Update on Neurolotology," John Dickins, M.D., Little Rock, moderator. Special event: "Euphonious Cords". Special guest speaker to be announced.

Arkansas Chapter of the American College of Radiology will hold a general business meeting from 1:30 p.m. until 3:30 p.m., Saturday, May 5th.

Arkansas Orthopaedic Society will meet from 1:30 p.m. until 3:30 p.m., on Saturday, May 5th. A general business session will begin at 1:30 p.m. followed by clinical talks. Speakers to be announced.

Arkansas Psychiatric Society will meet from 1:30 p.m. until 3:30 p.m., on Saturday, May 5th. "Anxiety and Depression: One or Two Disorders" will be discussed by Gary D. Tollefson, M.D., Ph.D., Chairman, Department of Psychiatry, St. Paul-Ramsey Medical Center, Minneapolis, Minnesota.

Arkansas Society of Plastic and Reconstructive Surgeons will hold a general business meeting from 1:30 p.m. until 3:30 p.m., Saturday, May 5th.

Arkansas Urologic Society will meet from 11:00 a.m. until 3:00 p.m., on Saturday, May 5th. Dr. Rodney J. Taylor will be the guest speaker.

Memorial Service

Members of the Arkansas Medical Society and Auxiliary who have died during this past year will be remembered during the Memorial Service at 3:45 p.m., Saturday, May 5th. Members to be honored are:

Society Members

Bob G. Banister, Conway
Hal R. Black, Jr., Little Rock
Vernon H. Carter, Elkins
William R. Cothern, Memphis, Tennessee
James C. Dunbar, Mountain Home
James W. Durham, Jacksonville
Jack W. Kennedy, Arkadelphia
John S. McKinney, El Dorado
Woodbridge E. Morris, Little Rock
Monroe B. Painter, Fayetteville
Ted H. Pye, Nashville
Edward Safranek, Fort Smith
Irving J. Spitzberg, Little Rock
Albert W. Strauss, Little Rock
H. King Wade, Hot Springs

Auxiliary Members and Spouses

Mrs. Vernon H. Carter, Elkins
Mrs. Ellis Cope, Little Rock
Mrs. Richard L. Daniel, Little Rock
Mrs. Walter H. Faust, North Little Rock
Mr. Darryl Hiers, Jonesboro
Mrs. Jerome S. Levy, Fort Collins, Colorado
Mrs. J. M. Robinson, Little Rock
Mrs. Kenneth A. Seifert, Hot Springs
Mrs. William A. Snodgrass, Jr., Mobile, Alabama
Mrs. Howard S. Stern, Pine Bluff

Convention Officials

Glen F. Baker, M.D., Little Rock, chairman
Carlos Araoz, M.D., Little Rock
Charles H. Rodgers, M.D., Little Rock
Walter O'Neal, M.D., Little Rock
F. Patrick Maloney, M.D., Little Rock
Brenda N. Powell, M.D., Hot Springs
Joe H. Stallings, Jr., M.D., Jonesboro
James R. Weber, M.D., Jacksonville (ex-officio)
William N. Jones, M.D., Little Rock (ex-officio)
Mrs. William E. Harrison, Little Rock (ex-officio)

Continuing Medical Education Credit

As an organization accredited for continuing medical education, the Arkansas Medical Society Committee on Scientific Programs certifies that this continuing medical education activity meets the criteria for hour-for-hour credit in Category I of the Physician's Recognition Award of the American Medical Association.

Building for the Future
Targeting Medicine in the '90's

Arkansas Medical Society Auxiliary

66th Annual Session
May 3-5, 1990
Arlington Hotel
Hot Springs, Arkansas

Registration

Mezzanine

Thursday	1:00 p.m. - 5:00 p.m.
Friday	7:30 a.m. - 5:00 p.m.
Saturday	7:30 a.m. - 5:00 p.m.

Official honorary hostesses for the 66th Annual Session are past presidents of the Arkansas Medical Society Auxiliary.

Thursday, May 3, 1990

2:00 p.m.

Pre-Convention Board Meeting

Magnolia Room - All State Officers, State Committee Chairmen, County Presidents, County President-elects, and Past State Presidents. All new Board members for 1990-91 are cordially invited to attend.

7:00 p.m.

AMSA/AMS Presidents' Reception and Silent Auction

Ballroom

Friday, May 4, 1990

8:00 a.m.

Continental Breakfast, Members, and Guests

Magnolia Room

8:30 a.m.

"The Pitfalls of Investments - How to Manage Your Husband's Money", Rick Adkins, President, The Arkansas Financial Group, Inc.



Rick Adkins

9:30 a.m.

Opening General Session

Magnolia Room - Mrs. Larry Lawson, President, presiding

General Business; Roll Call and Seating of County Delegates

Introduction of Special Guests:

Mrs. William C. Tippens Jr.
Robert E. McAfee, M.D.
James Weber, M.D.
William Jones, M.D.
Mr. Ken LaMastus
Ms. Peggy Pryor Cryer



Mrs. William Tippens Jr.

Address:

Mrs. William C. Tippens Jr., Southern Regional Vice President, American Medical Association Auxiliary.

Convention Announcements:

Mrs. William E. Harrison, Jr., Convention Chairman.

Reports of Officers and Committee Chairmen

Unfinished Business

New Business

Election of the Nominating Committee
(2 from the Board; 2 from the House of Delegates).

Election of Delegates and Alternates to the 1990 American Medical Association Auxiliary Convention.

Presentation of the 1990-91 Budget:
Mrs. Walter Mizell, Finance Chairman

Adjournment

11:45 a.m.

Shuffield Lecture/Luncheon and Awards Presentation
Ballroom - "Impact of a Changing Population'', Henry Cisneros, Former Mayor of San Antonio, Texas.

2:00 p.m.

Historic Downtown Walking Tour
Fordyce Bath House, Art Galleries, Art Center. Tea will be served at 4:00 p.m.

6:30 p.m.

Blue Cross Blue Shield Reception
Conference Center C

Saturday, May 5, 1990

8:00 a.m.

Past Presidents' Breakfast
Wine & Cheese Room

8:15 a.m.

Continental Breakfast, Members and Guests
Magnolia Room

8:45 a.m.

"Time Management", Mrs. John Bale.

9:30 a.m.

Second General Session
Magnolia Room - Mrs. Larry Lawson, President, Presiding.

General Business

Greetings from Southern:
Mrs. A. J. Campbell, President, Southern Medical Association Auxiliary.


Mrs. A.J. Campbell

Reports by County Presidents:

Moderators: District Vice Presidents
Northeast: Mrs. Joe T. Wilson
Northwest: Mrs. Charles Brown
Southeast: Mrs. Jerry Thomas
Southwest: Mrs. Allen Lee

Unfinished Business

New Business
Report of the Nominating Committee:
Mrs. Ray Jouett
Election of Officers

Adjournment

12:15 p.m.

Luncheon
Belvedere Country Club - Hostess: Pope County

Invocation:
Mrs. Jerry Blaylock

Presiding: Mrs. Larry Lawson, President

Introduction of Guests

Presentation of Awards:

AMA-ERF:
Mrs. Jerry Holton, Chairman

Vinne E. Garrison Memorial Award:
Mrs. Cecil Cupp, Chairman

Membership Award:
Mrs. David Williams, Chairman

Doctors' Day Award:
Mrs. David Jacks, Southern Medical Auxiliary Councilor

Installation of Officers:
Mrs. William C. Tippens, Jr., Southern Regional Vice President, American Medical Association Auxiliary.

2:30 p.m.

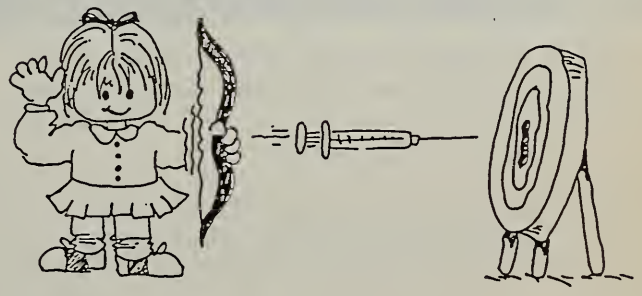
Post Convention Board Meeting
Belvedere Country Club

3:45 p.m.

Memorial Service
Conference Center B

7:00 p.m.

Inaugural Banquet and Entertainment
Ballroom



Scenes From the 1989 Annual Session
Arlington Hotel
Hot Springs, Arkansas









AMS Member and Spouse Registration Form

Please check: _____ AMS Registration _____ Spouse Registration

Dr. _____
(Please Print)

Mr./Mrs. _____
(First and Last Name)

Title _____
(Delegate, Officer, Councilor)

Specialty _____

Address _____

City _____ State _____ Zip _____ County _____

Registration Fees: *(Fee covers Silent Auction, Shuffield Luncheon and Inaugural Banquet, Exhibit Hall Luncheon and entrance into the Exhibit Hall. - No one will be allowed in the exhibit area without a registration badge.)*

	Pre-Paid	**On-Site**
Member	$60.00	$ 75.00
Spouse	$40.00	$ 55.00
Non-Member	$95.00	$110.00
Students/Residents	No Charge with proper I.D.	

Additional Tournament Charges *(Optional):*
Participants must pre-register. Fees are per person.

____Golf $35.00 ____ Tennis $20.00

For appropriate meal count, please check if you will be attending:

____ Shuffield Luncheon ____ # Attending
____ Inaugural Banquet ____ # Attending

Total Amount Enclosed $_____

Auxiliary Registraton Form

____Mr.
____Mrs. _____
(Please Print)

Address _____

City _____ State _____ Zip _____ County _____

Title (Officer) _____

Registration Fees: *(For Auxiliary events)*

Luncheon	***Tea***
$15.00	$8.00

The Auxiliary tickets are not included in the AMS Registration fee of $40.00 and must be purchased separately.

Total Amount Enclosed: $_____

If you plan to attend both the AMS and Auxiliary events, you must complete and return both forms.
Checks for member, spouse and auxiliary registration should be made payable and forwarded with the registration form to:

Arkansas Medical Society
P.O. Box 5776
Little Rock, AR 72215

House of Delegates

The opening session of the House of Delegates of the Arkansas Medical Society will begin at 5:00 p.m. on Thursday, May 3rd. Speaker of the House John Crenshaw, M.D., will preside, assisted by Vice Speaker Kelsy J. Caplinger, III, M.D.

All items of business to be considered by the House must either be printed in the convention issue of the ***Journal*** or submitted to the headquarters office in writing twenty days prior to the meeting. Any new business proposed during the session of the House of Delegates must have a two-thirds vote of attending delegates for introduction.

Items of business will be referred by the Speaker of the House of Delegates to one of three reference committees. Open hearings on those items of business will be held by the reference committees on Friday, May 4th at 10:30 a.m. All members of the Society are welcome to attend the meetings of the reference committees and to express views on the various reports, resolutions, etc.

The following will be seated at the House of Delegates meeting during the 1990 Annual Session:

Officers

John Crenshaw, Pine Bluff, Speaker, (ex-officio)
Kelsy J. Caplinger, III, Little Rock, Vice Speaker, (ex-officio)
James R. Weber, Jacksonville, President (ex-officio)
William N. Jones, Little Rock, President-elect (ex-officio)
Michael N. Moody, Salem, First Vice President (ex-officio)
Charles H. Rodgers, Little Rock, Secretary (ex-officio)
James M. Kolb, Jr., Russellville, Treasurer (ex-officio)

Councilors

District 1:	J. Larry Lawson, Paragould
	Merrill J. Osborne, Blytheville
District 2:	John E. Bell, Searcy
	Jim E. Lytle, Batesville
District 3:	L. J. P. Bell, Helena
	Hoy B. Speer, Jr., Stuttgart
District 4:	Paul A. Wallick, Monticello
	Lloyd G. Langston, Pine Bluff
District 5:	Cal R. Sanders, Camden
	Wayne G. Elliott, El Dorado
District 6:	James D. Armstrong, Ashdown
	F. E. Joyce, Texarkana
District 7:	Ronald J. Bracken, Hot Springs
	Thomas H. Hollis, Hot Springs
District 8:	Glen F. Baker, Little Rock
	David L. Barclay, Little Rock
	Paul Cornell, Little Rock
	Warren Douglas, Little Rock
	Charles Logan, Little Rock
	R. Jerry Mann, Little Rock
	Harold Purdy, Little Rock
District 9:	Robert H. Langston, Harrison
	David L. Rogers, Fayetteville
District 10:	Morton C. Wilson, Fort Smith
	Gerald A. Stolz, Russellville
	A. C. Bradford, Fort Smith

Past Presidents (ex-officio)

Charles R. Henry, Sr., Little Rock
Joe Verser, Harrisburg
C. Randolph Ellis, Malvern
Joseph A. Norton, Little Rock
H. W. Thomas, Dermott
Ross E. Fowler, Harrison
C. Stanley Applegate, Jr., Springdale
C. Robert Watson, Little Rock
John P. Wood, Mena
Ben N. Saltzman, Little Rock
T. E. Townsend, Pine Bluff
Albert S. Koenig, Jr., Fort Smith
W. Payton Kolb, Little Rock
George F. Wynne, Warren
A. E. Andrews, Jr., Texarkana
Kemal E. Kutait, Fort Smith
Purcell Smith, Jr., Little Rock
Morriss M. Henry, Fayetteville
Asa A. Crow, Paragould
Charles F. Wilkins, Jr., Russellville
John P. Burge, Lake Village
C. C. Long, Fort Smith (Honorary)
Ken Lilly, Fort Smith
W. Ray Jouett, Little Rock
John M. Hestir, DeWitt

Ex-officio members shall have the power of voting on all subjects except the election of officers.

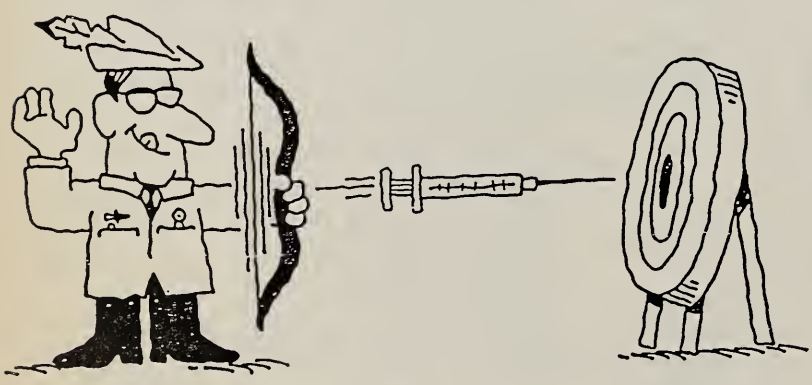
Delegates for 1990 (as submitted by county)

	Delegate	Alternate Delegate
Arkansas (1)	Dennis B. Yelvington	Noble B. Daniel
Ashley (1)	D. L. Toon	Curtis E. Ripley
Baxter (1)	Robert L. Baker	Peter A. MacKercher
Benton (3)	William T. Summerlin	
	Stephen L. Goss	
Boone (1)	John T. Troupe	Carlton L. Chambers
Bradley (1)	Joe H. Wharton	George F. Wynne
Carroll (1)		
Chicot (1)	Danny T. Berry	Tom Tvedten
Clark (1)	Noland H. Hagood	James L. Lowry
Cleburne (1)	Thomas L. Eans	J. Warren Murry
Columbia (1)	H. Scott McMahen	John E. Alexander, Jr.
Conway (1)		
Craighead/		
Poinsett (5)	Jerry D. Blaylock	
	Ray H. Hall, Jr.	
	David Pyle	
	Joe H. Stallings, Jr.	
	Don B. Vollman, Jr.	
Crawford (1)		
Crittenden (1)	Steve P. Schoettle	Edgar S. Ferguson
Cross (1)	James T. Beaton	Robert A. Hayes
Dallas (1)	Jack T. Dobson	
Desha (1)	Guy U. Robinson	Howard R. Harris
Drew (1)		
Faulkner (1)	J. J. Magie	Robert B. Rook
Franklin (1)	David L. Gibbons	
Garland (5)	Ronald J. Bracken	
	J. Richard Gardial	
	Doane M. Newton	
	Eugene M. Shelby	
	James L. Gardner	
Grant (1)		
Greene/		
Clay (1)	Richard O. Martin	J. Darrell Bonner
Hempstead (1)		
Hot Spring (1)		
Howard/		
Pike (1)	Robert R. Sykes	Joe D. King
Independence(1)	Lloyd G. Bess	John R. Baker
Jackson (1)		
Jefferson (4)	Lee A. Forestiere	
	Kenneth A. Martin	
	Simmie Armstrong, Jr.	
	Anna T. Ridling	
Johnson (1)	Don Pennington	
Lafayette (1)	Sanford E. Hutson	
Lawrence (1)	Ralph F. Joseph	Sebastian A. Spades III
Lee (1)		
Little River (1)	Robert D. Dalby	Joseph G. Shelton, Jr.
Logan (1)	John R. Willliams	Guy Ulrich
Lonoke (1)	Jerry C. Chapman	Leslie F. Anderson
Miller (3)	John A. Gillean	
	Donald L. Duncan	
	Herbert B. Wren	
Mississippi (1)	Eldon Fairley	Clinton G. Melton
Monroe (1)	Neylon C. David	
Nevada (1)	H. Blake Crow	Charles A. Vermont
Ouachita (1)	William D. Dedman	Lawrence F. Braden
Phillips (1)	L. J. P. Bell	Robert D. Miller, Jr.
Polk (1)	John H. Finck	John D. Mesko
Pope (2)	Homer K. Beavers	
	Michael F. Bell	
Pulaski (28)	Durwood B. Allen, Jr.	James H. Adametz
	Carlos A. Araoz	A. J. Brizzolara
	Raymond V. Biondo	Ashley Brunson
	Warren C. Boop, Jr.	Philip J. Deer, III
	Curry B. Bradburn, Jr.	William E. Golden
	Scott H. Brown	A. David Hall
	Kelsy J. Caplinger, III	D. Andrew Henry
	Gilbert O. Dean	J. Timothy Hodges
	Marlon Doucet	Jerry C. Holton
	Charles P. Fitzgerald	Richard Houk
	Gene L. France	Coburn S. Howell
	James L. Hagler	Harold G. Hutson
	Edwin Hankins, III	G. Thomas Jansen
	Fred O. Henker, III	Gail R. Jones
	Charles R. Henry, Sr.	John C. Jones
	Fred J. Kittler	William T. Mabrey
	Marvin Leibovich	Stephen K. Magie
	J. Mayne Parker	Michael M. Moore
	John D. Pike	Rex N. Moore
	John F. Redman	Steven Nokes
	Charles H. Rodgers	George A. Norton
	Ashley S. Ross, Jr.	Charles E. Pearce
	Ben N. Saltzman	Michael C. Roberson
	Bruce E. Schratz	Edward H. Saer
	Robert F. Shannon	Alan R. Storeygard
	Frank M. Sipes	Thomas Wortham
	Robert Valentine, Jr.	
Randolph (1)	Albert L. Baltz	Andrew J. Jansen
Saline (1)	Marvin N. Kirk, Jr.	Frank E. Thibault, Jr.
Sebastian (8)	R. Cole Goodman, Jr.	Jimmie G. Atkins
	A. Samuel Koenig, III	Randy Ennen
	John R. Lange	David W. Hunton
	Andre J. Nolewajka	David B. Kocher
	McDonald Poe, Jr.	Steve B. Nelson
	William H. Schemel	Jerry R. Stewart
	John R. Swicegood	John D. Wells
	Carl L. Williams	John H. Wikman
Sevier (1)		
St. Francis (1)	Samual A. McGuire	
Tri-County (1)	Michael Moody	William Relyea
Union (2)	Larkus H. Pesnell	Wayne Elliott
	Bert Dougherty	
Van Buren (1)	John A. Hall	Charles G. Pearce
Washington (5)	Anthony N. Hui	
	William B. Nowlin	
	Danny L. Proffitt	
	David L. Rogers	
	Janet L. Titus	
White (2)	Kenneth R. Meacham	
	Daniel S. Davidson	
Woodruff (1)	James E. Rowe	
Yell (1)	James L. Maupin	Gene D. Ring
Resident Physician Section (1)	David M. Halinski	
Medical Student Section (1)	John Gaston	Donald E. Steely

First Meeting, House of Delegates

5:00 p.m., Thursday, May 3rd
John Crenshaw, M.D., Speaker
Kelsy J. Caplinger, III, M.D., Vice Speaker

1. Call to order
2. Presentation of the Colors
3. Welcome to Hot Springs
4. Introduction of guests:
   Mrs. William C. Tippens, Jr., Chairman
   Southern Regional Vice President
   American Medical Association Auxiliary
   Mrs. J. Larry Lawson, President
   Arkansas Medical Society Auxiliary, Paragould
   Mrs. David Williams, President-elect
   Arkansas Medical Society Auxiliary, Russellville
5. Address by Robert E. McAfee, M.D., Board of Trustees, American Medical Association, South Portland, Maine
6. Address by the President of the Arkansas Medical Society, James R. Weber, M.D., Jacksonville
7. Adoption of minutes of the 113th Annual Session as published in the June 1989 issue of the ***Journal of the Arkansas Medical Society***.
8. Presentations
9. New Business
   All reports, resolutions, and other items of business received by the headquarters office twenty days prior to the meeting shall be included in the agenda. Any items of business received after April 13th, must have two-thirds consent of attending delegates before introduction. All items will be referred to reference committees.
10. Announcement of vacancies on State Boards:
    Arkansas State Medical Board (Member-at-Large)
    Arkansas State Board of Health (Second and Fourth Congressional Districts.)
11. Recess until Saturday



Final Meeting, House of Delegates

4:15 p.m., Saturday, May 5th
John Crenshaw, M.D., Speaker
Kelsy J. Caplinger, III, M.D., Vice Speaker

1. Call to order
2. Election of officers. Nominations as submitted by the Nominating Committee:
   President-elect:
   George W. Warren, M.D., Smackover
   Charles F. Wilkins, Jr., M.D., Russellville
   First Vice President:
   Michael N. Moody, M.D., Salem
   Second Vice President:
   Linda A. Markland, M.D., Fayetteville
   Third Vice President:
   J. Warren Murry, M.D., Heber Springs
   Treasurer:
   James M. Kolb, Jr., M.D., Russellville
   Secretary:
   Charles H. Rodgers, M.D., Little Rock
   Speaker of the House:
   John Crenshaw, M.D., Pine Bluff
   Vice Speaker of the House:
   Kelsy J. Caplinger, III, M.D., Little Rock
   Delegates to the AMA (1/1/91 - 12/31/92)
   John P. Burge, M.D., Lake Village
   A. E. Andrews, M.D., Texarkana
   Alternate Delegates to the AMA (1/1/91-12/31/92):
   David L. Rogers, M.D., Fayetteville
   John M. Hestir, M.D., DeWitt
   Councilors:
   District 1:
   J. Larry Lawson, M.D., Paragould
   District 2:
   John E. Bell, M.D., Searcy
   District 3:
   L. J. P. Bell, M.D., Helena
   District 4:
   Paul A. Wallick, M.D., Monticello
   District 5:
   Cal R. Sanders, M.D., Camden
   District 6:
   James D. Armstrong, M.D., Ashdown
   District 7:
   Ronald J. Bracken, M.D., Hot Springs
   District 8:
   David Barclay, M.D., Little Rock
   R. Jerry Mann, M.D., Little Rock
   Harold D. Purdy, M.D., Little Rock

District 9:
Robert H. Langston, M.D., Harrison
District 10:
Gerald A. Stolz, Jr., M.D., Russellville
Morton C. Wilson, M.D., Fort Smith

3. Address by M. Joycelyn Elders, Director
Arkansas Department of Health
4. Reports of Reference Committees:
Committee #1: Gene L. France, M.D., Chairman
Committee #2: Joe Wharton, M.D., Chairman
Committee #3: Steve P. Schoettle, M.D., Chairman
5. Supplemental report of the Council:
J. Larry Lawson, M.D., Chairman
(Report covers meetings of the Council held during the annual session.)
6. New Business:
Announcement of nominees for the Arkansas State Medical Board and the Arkansas State Board of Health
Other new business
Medical Student and Resident Physician Observers will be announced at the meeting.

Reference Committees

Reference Committees are appointed by the Speaker of the House of Delegates to consider the various reports and resolutions. Reports published in this issue of the *Journal*, as well as any reports and resolutions presented at the first meeting of the House on May 3rd, will be referred by the Speaker to the reference committees. The committees will hold open hearings at 10:30 a.m. on Friday, May 4th. After the hearings, the reference committees will hold executive sessions for the purpose of preparing recommendations and reports for the House of Delegates. Reports of the Reference Committees will be acted upon by the House of Delegates at the Saturday session. Reference Committee members are as follows:

Reference Committee #1

Gene L. France, Little Rock, Chairman
David Pyle, Jonesboro
Janet Titus, Winslow
Dennis B. Yelvington, Stuttgart.

Reference Committee #2

Joe Wharton, Warren, Chairman
J. Mayne Parker, Little Rock
William D. Dedman, Camden
Anthony N. Hui, Fayetteville.

Reference Committee #3

Steve P. Schoettle, West Memphis, Chairman
Simmie Armstrong, Jr., Pine Bluff
John L. Lange, Fort Smith.
Amail Chudy, Little Rock

Meetings of the Council

The Council will meet at the following times:

Thursday, May 3	3:30 p.m.
Friday, May 4	4:15 p.m.
Saturday, May 5	8:45 a.m.

Immediately following adjournment of the House of Delegates (brief organizational meeting and group photographs of new officers).

State Board Vacancies

Arkansas State Board of Health

A vacancy will occur December 31, 1990, in the Second and Fourth Congressional District positions of the Arkansas State Board of Health. Members from the counties in the district are urged to meet immediately following the adjournment of the House of Delegates on Thursday to vote for nominees. The term of office is four years. Nominations should be reported to the Society personnel immediately following the caucuses (only one nomination is required).

Second Congressional District: Kenneth R. Meacham, of Searcy, is currently serving the term which will expire in December 1990. Dr. Meacham is eligible to succeed himself.

Counties in the Second Congressional District include Cleburne, Fulton, Independence, Izard, Jackson, Lawrence, Monroe, Prairie, Randolph, Sharp, Stone, White, and Woodruff.

Fourth Congressional District: Wayne G. Elliott, of El Dorado, is currently serving the term which will expire in December 1990. Dr. Elliott is eligible to succeed himself.

Counties in the Fourth Congressional District include Ashley, Bradley, Calhoun, Clark, Columbia, Hempstead, Howard, Little River, Lafayette, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier, and Union.

Arkansas State Medical Board

A vacancy will occur December 31, 1990, in the member-at-large position of the Arkansas State Medical Board. The term of office will be for eight years. At-large nominees are selected by the Society's Nominating Committee and approved by the House of Delegates.

W. Ray Jouett is currently serving the term which will expire in December, 1990. Dr. Jouett is eligible to succeed himself.

Resolutions

Resolution from the Young Physicians Committee Concerning Disability and Health Insurance Protection for Health Care Workers with AIDS

Whereas, AIDS is unquestionably one of the greatest health concerns facing both patients and physicians, and

Whereas, there is a growing concern within the medical profession in regard to the accurate documentation and subsequent care of HIV infected health care workers, and

Whereas, the ability of HIV positive health care workers to practice their profession is unquestionably jeopardized; therefore be it

Resolved, that the Arkansas Medical Society's Committee on AIDS investigate the policies and responsibilities of health and disability insurance companies as they relate to HIV infection, and further be it

Resolved, that the Committee on AIDS determine if hospitals and other employers of health care workers have written policies regarding HIV infected health care workers, and if so, what they are.

Resolution from the Pulaski County Medical Society Concerning Opposition to Mandatory Substitution

Whereas, in 1989 the Committee on Drugs and Devices of the American Academy of Family Physicians (AAFP) completed a review of the medical literature regarding generic drugs, and

Whereas, the study by the AAFP revealed reason for concern related to the safety and efficacy of generic drug products, and

Whereas, the AAFP has taken a position stating that there are critical patients, critical diseases, and critical drugs in which there should be ***no mandatory substitution*** of a generic product for a brand name product, and

Whereas, many members of the Arkansas Medical Society (AMS) provide care to Arkansans who have the cost of their health care provided by agencies (Medicaid) and third-party payors which require mandatory substitution of drug products, and

Whereas, as their patients' advocates, the members of the AMS have the ultimate responsibility for the health care of their patients; therefore let it be

Resolved, that the AMS supports the stand taken by the AAFP regarding the mandatory substitution of generic drugs for brand name drugs in critical patients, critical diseases, and critical drugs, and be it further

Resolved, that the AMS support legislative activity directed toward the prevention of mandatory substitution of generic drug products for the brand name product and, be it further

Resolved, that the AMS educate its members regarding the generic drug approval process used by the U.S. Food and Drug Administration, and be it further

Resolved, that the AMS encourage the AMA to adopt a similar policy statement.

Resolution from the Young Physicians Committee Concerning Tort Reform

Whereas, tort reform is one of the major political issues directly affecting the cost of the practice of medicine, and

Whereas, the Georgetown Research Project is an ongoing preliminary study involving five states (the closest being Mississippi) in which an attempt is being made to install a No-fault Workers' Compensation Board rather than the tort system to hear and decide on medical malpractice cases; therefore be it

Resolved, that an appropriate committee of the Arkansas Medical Society monitor and report back the activities of this major American Medical Association effort concerning tort reform.

Resolution from the Young Physicians Committee Concerning Uninsured Patients

Whereas, the problem of 37 million Americans without health insurance, including the uninsured "dependent" population, is being addressed by the American Medical Association, and

Whereas, the Arkansas Medical Society has begun the Arkansas Health Care Access Foundation to provide free initial visits for qualifying patients in a statewide indigent patient care effort; therefore be it

Resolved, that the Arkansas Medical Society be congratulated for taking a leadership role in this endeavor and make public through the media these commendable efforts along with details on further programs to be undertaken by the physicians of this state to reaffirm our recognition of and continued efforts to resolve these problems.

Resolution from the Young Physicians Committee Concerning the Workers' Compensation Ruling

Whereas, the present Workers' Compensation Commission ruling in the Coleman vs. Holiday Inn case could result in a portion of the physician's reimbursement being awarded to attorneys in workers' compensation cases, and

Whereas, the Arkansas Medical Society has filed an appeal along with other affected groups to overturn this unfair ruling; therefore be it

Resolved, that the Young Physicians Committee formally acknowledge its support of the Arkansas Medical Society in their efforts to appeal this precedent setting decision.

Take the First Step to Recovery

The Physicians Health Committee exists for you!

The committee is composed of physicians who have "been there" and want to help their colleagues who are struggling with drug or alcohol addiction.

Don't throw away your profession because of drugs and alcohol. Contact our Physicians Confidential Assistance Hotline:

(501) 370-8221

AMS Directory Update

By now you should have received your Type of Practice (TOP) informational sheet.
This information is used for the 1990 AMS Membership Directory.
Please send your sheet to the Society office today.

Arkansas Medical Society
PO Box 5776
Little Rock, Arkansas 72215

Nominating Committee

Nominating Committee
Charles Logan, M.D., Chairman

The Nominating Committee met November 19, 1989, following the AMS Council meeting. We wish to present to the Society the following nominees:

President-elect:
- George W. Warren, M.D., Smackover
- Charles F. Wilkins, Jr., M.D., Russellville

First Vice President:
- Michael N. Moody, M.D., Salem

Second Vice President:
- Linda A. Markland, M.D., Fayetteville

Third Vice President:
- J. Warren Murry, M.D., Heber Springs

Treasurer:
- James M. Kolb, Jr., M.D., Russellville

Secretary:
- Charles H. Rodgers, M.D., Little Rock

Speaker of the House:
- John Crenshaw, M.D., Pine Bluff

Vice Speaker of the House:
- Kelsy J. Caplinger, III, M.D., Little Rock

Delegates to the AMA (1/1/91 - 12/31/92):
- John P. Burge, M.D., Lake Village
- A. E. Andrews, M.D., Texarkana

Alternate Delegates to the AMA (1/1/91 - 12/31/92):
- David L. Rogers, M.D., Fayetteville
- John M. Hestir, M.D., DeWitt

Councilors:
- District 1:
  - J. Larry Lawson, M.D., Paragould
- District 2:
  - John E. Bell, M.D., Searcy
- District 3:
  - L. J. P. Bell, M.D., Helena
- District 4:
  - Paul A. Wallick, M.D., Monticello
- District 5:
  - Cal R. Sanders, M.D., Camden
- District 6:
  - James D. Armstrong, M.D., Ashdown
- District 7:
  - Ronald J. Bracken, M.D., Hot Springs
- District 8:
  - David Barclay, M.D., Little Rock
  - R. Jerry Mann, M.D., Little Rock
  - Harold D. Purdy, M.D., Little Rock
- District 9:
  - Robert H. Langston, M.D., Harrison
- District 10:
  - Gerald A. Stolz, Jr., M.D., Russellville
  - Morton C. Wilson, M.D., Fort Smith

Business Reports

Committee on AIDS
William N. Jones, M.D., Chairman

The Arkansas Medical Society Committee on AIDS held ten formal meetings and additional subcommittee meetings during 1989. The hallmark of this committee has continued to be excellent enthusiastic participation and contribution by its members. During 1989, the committee members were: Drs. William N. Jones, chairman, Joseph Beck II, Donald C. Fournier, Linda A. Markland, E. Clinton Texter Jr., A. Stuart Fitzhugh, Charles R. Henry Sr., William L. Mason, Ishmael Reid Jr., Eugene M. Shelby, Harold Hedges, J.P. Lofgren, Donald G. Browning, James W. Durham, April Jackson, RN, MSN, medical students Lee Fleming and Tim Coalwell, Mrs. Arleta Power and Mr. Paul Harris.

This past year, many more physicians in Arkansas had their first direct contact with Human Immunodeficiency Virus (HIV) infected patients. The need to know all we can about HIV will increase with each passing month, since the epidemic continues to expand and the incubation period is now known to be over ten years. It must be remembered that HIV infection is a continuum of disease leading to death. No comfort is given by the recent change in the estimate of HIV infected persons in the United States from 1.5 down to 1.3 million. Originally, 365,000 persons were predicted to have developed AIDS by the end of 1992, and that figure has been revised to 310,000 persons. The press calls the epidemic "exaggerated"!

There have been more than 116,000 cases and over 67,500 deaths from AIDS in the United States reported to the Centers for Disease Control since 1981. Arkansas has experienced 252 cases and 155 deaths since 1985. Underreporting, due to apathy and physician burnout in high prevalence areas, leave in doubt the accuracy of the number of reported cases.

1989 brought no new antiviral drugs for HIV infection. However, new approaches in the control of opportunistic infections did occur, the most notable of which was the FDA approval for the use of Pentamidine aerosol for prophylaxis against Pneumocystis carinii pneumonia. AZT was shown to be effective in delaying the onset of AIDS in adults with asymptomatic HIV infection. Vaccine research continued. So it remains as true today as it was when first stated, that prevention of infection through education and behavior modification are our most important tools to slow the spread of this fatal viral epidemic.

During 1989, the committee has:

* Started a joint project with the Arkansas Department of Education to take AIDS education to the students (elementary through high school) of the sixteen education co-ops. The program was kicked off by conducting an AIDS symposium for the 84 participants at the Arkansas Department of Education - AIDS Education Resource Training Workshop on April 12, 1989 in Little Rock. Since then, we have conducted seminars for seven co-ops attended by over 750 classroom teachers.
* Continued to publish in the ***Journal of the Arkansas Medical Society*** monthly educational articles on HIV related issues and treatment, with statistical updates on AIDS in Arkansas provided by the Arkansas Department of Health.
* Received the 1989 Youth AIDS Education Award from the Arkansas AIDS Foundation for our cooperative project with the Arkansas Department of Education.
* Dr. Beck received an Excellence in Health Care Award from the Arkansas AIDS Foundation for his personal efforts in the HIV epidemic.
* Began a study of the economic impact of the AIDS epidemic on Arkansas hospitals.
* Successfully lobbied for the passage of House Bill 1565, now Act 413 of 1989, signed by Governor Clinton on March 8, 1989, entitled "AN ACT TO REQUIRE ANY PERSON WHO IS FOUND TO HAVE HIV INFECTION TO SO ADVISE ANY PHYSICIAN OR DENTIST BEFORE RECEIVING HEALTH CARE SERVICES OF SUCH PHYSICIAN OR DENTIST . . ."
* Successfully lobbied for the passage of House Bill 1496, now Act 614 of 1989 signed by Governor Clinton on March 16, 1989, entitled "AN ACT TO CREATE A CRIME FOR KNOWINGLY AND WILLFULLY EXPOSING ANOTHER PERSON TO HUMAN IMMUNODEFICIENCY VIRUS, THE VIRUS WHICH CAUSES ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)."
* Endorsed and sent letters of support to our United States Senators and Congressmen for Congressman William E. Dannemeyer's bill HR3102 entitled, "Public Health Response to AIDS - Act of 1989".
* Dr. Jones and the Arkansas Delegation at the AMA Interim Meeting in Honolulu, Hawaii, December 3-6, 1989, were successful in the House of Delegates in passing two amendments to Report X (I-89) of the Board of Trustees - AMA HIV Policy Update, which strongly recommends the reportability of HIV seropositive patients to the Departments of Health of the 50 states and strongly recommends a system of contact tracing and partner notification.
* Endorsed the Arkansas Department of Health applica-

tion to seek federal funding for an AIDS assessment study in Arkansas.

* Represented by Dr. Markland at the HIV - AIDS Tri-Regional Public Health Summit in Santa Fe, New Mexico, September 10-13, 1989.
* Represented by Dr. Beck at the Fifth International Conference on AIDS held in Montreal, Quebec, June 4-9, 1989.
* Sent the 1988 Annual Report of the Committee on AIDS
* Planned and organized our third annual statewide AIDS seminar to be held in Hot Springs, March 17, 1990. We are very fortunate to have as our keynote speaker, Dr. Marcus Conant, from San Francisco, California. Dr. Conant has been prominent in AIDS education and related issues, both nationally and internationally since the epidemic began in 1981. Other speakers include Drs. William Brandon, Charles Billings, John Ritchie (D.D.S.) of New Orleans, Robert Bradsher and W.A. Nichols (D.D.S.) of Little Rock. The program will include workshops targeting dentists, nurses, physicians, and nursing home administrators.
* Corresponded with the CDC, FDA, and the Arkansas Department of Health about regulations under which donor-paid plasma centers operate in regards to notification and reportability of HIV seropositive donors. Alerted our United States Senators and Congressmen about an apparent flaw in the regulations. We seek a change in policy that would require plasma centers to notify donors found to be seropositive for HIV.
* Applied for and received our third contract from the Arkansas Department of Health to continue our educational programs. The current grant runs to mid-1990 and was in the amount of $14,000. Unfortunately, the federal funds allocated for the next twelve months are designated for minority and high risk group projects, so our program no longer will qualify for assistance. We feel this is a mistake by the federal bureaucracy in attacking the AIDS epidemic.
* Continued to represent the Arkansas Medical Society on the AIDS Advisory Committee to the Arkansas Department of Health.
* Presented programs on AIDS education to 13 nursing home groups statewide, which had over 750 participants.
* Our educational programs have now been received by over 12,000 persons in Arkansas. F.A.T.E. students have presented to over 5,000 students in 35 schools.

This will be my last annual report on the activities of the Committee on AIDS. Dr. Beck has accepted my request that he succeed me as chairman. He will bring a fresh enthusiasm and commitment to continue this important work.

My experiences on this exciting and productive committee have been the most gratifying of any with which I have been involved with in organized medicine.

Thanks to everyone, including members of the committee, the staff of the Arkansas Medical Society (particularly Laura Harrison and Peggy Cryer), the volunteer physicians and auxilians, the medical students of F.A.T.E., and the Arkansas Department of Health, all of whom have contributed and made this a successful effort for the good of the public health by the Arkansas Medical Society.

Annual Session Committee
Glen F. Baker, M.D., Chairman

A review of the 1989 Annual Session evaluations indicated this year's program was a tremendous success. We used an entirely new format which was very successful. The changes included the following: 1) shortened the length of the program from four to two and one-half days, 2) targeted socioeconomic programs, 3) designated specific exhibit times, 4) invited humorist entertainment to the President's Inaugural Banquet, and 5) charged a nominal registration fee.

Because of the new format, we had an increase in physician attendance, praise from exhibitors for the increased traffic through the exhibit area, and the enjoyment of completing our scheduled meeting on a humorous note. This was also the first year in the history of the Arkansas Medical Society that the Annual Session has paid for itself rather than being supplemented by the Society's general operating budget - a true milestone.

Preparations are now underway to continue the new format for the 1990 program and to surpass last year's success both in information and entertainment.





Budget Committee
L. J. P. Bell, M.D., Chairman

The Budget Committee submitted the following budget for 1990. The complete budget, as presented to the Council, is available to members upon request.

Income	*Amount Budgeted*
AMS Dues	$545,000.00
Journal Advertising	50,000.00
Booth Income	28,000.00
Annual Session	23,000.00
AMA Reimbursement	5,800.00
Miscellaneous	8,400.00
Interest Income	74,000.00
Specialty Desk	600.00
CME	1,500.00
Rent, F.O. & Land Income	63,785.00
AIDS Grant	14,000.00
*Allocation G.A. Depart	5,000.00
Total	$819,085.00

Expenses	
Salaries	$222,720.00
Travel & Convention	55,000.00
President's Account	4,000.00
Taxes	22,400.00
Retirement	22,865.00
Stationary & Printing	10,500.00
Office Supplies & Exp.	19,000.00
Telephone & Telegraph	11,000.00
Rent	132,000.00
Postage	23,500.00
Insurance & Bonds	41,300.00
Auditing	3,500.00
Council & Exec Comm.	3,000.00
Journal Expense	62,000.00
Dues & Subscriptions	3,000.00
Gifts & Contributions	2,200.00
Auxiliary	2,000.00
Legal Services (Retainer)	25,200.00
Special Committee	3,000.00
Public Relations	3,000.00
Miscellaneous Expenses	4,000.00
Office Equip. & Furniture	8,000.00
CME	1,000.00
Richmond Early Retirement	5,820.00
Contract Labor	750.00
Winter Meeting	2,500.00
AMS Resident & Student	4,500.00
AIDS Committee	14,000.00
Annual Session	50,000.00
Building Fund	30,000.00
Total	$791,755.00

Department of Governmental Affairs

Income	$186,000.00

Expenses	
Salaries	$ 72,250.00
Retirement	7,950.00
Taxes	6,900.00
Stationary & Printing	4,000.00
Office Sup.,Phone, Misc.	4,000.00
Equipment & Furniture	1,500.00
Auto, Travel, & Meetings	52,900.00
Legal Retainer	16,800.00
Postage	8,000.00
Insurance & Bonds	5,520.00
Office Allocation to AMS	5,000.00
Total	$184,820.00

Committee on Continuing Medical Education
Walter O'Neal, M.D., Chairman

The Committee on Continuing Medical Education (CME) exists to insure that Arkansas physicians have at their disposal a wide variety of high quality CME programs. To accomplish this, the Committee operates a voluntary accreditation program to sponsors of CME activities. Only accredited sponsors can offer AMA Category I credit. Currently nine organizations, mostly hospitals, are accredited by the AMS.

The Society's authority to accredit sponsors of CME is granted by the Accreditation Council for Continuing Medical Education (ACCME), which consists of representatives of seven national organizations: American Board of Medical Specialties, American Hospital Association, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, the Council of Medical Specialty Societies, and the Federation of State Medical Boards.

During 1989, the committee completed a two-year effort to update all of the accreditation guidelines and policies used to operate the program. Our efforts were rewarded by the ACCME by being granted "continued recognition" for a period of four years. We are very proud of this accomplishment and I personally would like to recognize the other members of this committee for their hard work: Drs. Warren Douglas, Robert Dickins, Gerald Stolz, Charles Mabry, I. Dodd Wilson, and Les Anderson.

The organizations that we accredit must be reaccredited periodically. Our accreditation period is usually two to four years, and at the end of each period, the organization must submit a new application and undergo a site inspection in order to be reaccredited. In 1989, six organizations were scheduled for reviews. Of these, three were granted four years accreditation, one was granted two years, one is pending, and one did not renew their

accreditation.

There has been increased interest over the past year in our accreditation program. Currently, two hospitals have applications for initial accreditation pending and another has expressed an interest. The fees for the accreditation program are as follows: initial and reaccreditation application fee, $300; annual reporting fee, $100; plus the organization pays the expenses for the physicians conducting the site inspection.

Report of the Council
J. Larry Lawson, M.D., Chairman

The Council met February 19, 1989, at the Holiday Inn West in Little Rock, and the following business was transacted:

1. Milton Deneke reported that the joint project with KATV, "House Calls", has been put on hold.
2. Approved the minutes of the December 11, 1988, council meeting.
3. Approved the minutes of the January 25, 1989, executive committee meeting as follows:
   a. Discussed the federal regulations on substandard care.
   b. Approved travel for James Weber, Charles Logan, and John Crenshaw to attend the AMA Leadership Conference.
   c. Approved the AMS joining a coalition concerning client assessment teams at the Department of Human Services. Other coalition members are associations representing medical equipment, hospitals, home health, and nursing homes. Mr. Jim Stockley is the coalition's lobbyist.
   d. Approved a $2,500 contribution to the coalition to defray costs.
   e. Recommended the Society's involvement and support of the Legislative Hospitality Room at the Holiday Inn. Estimated cost $3,000.
   f. Discussed the Health Department's Physician Office Lab Review Program.
4. Wayne Elliott, chairman of the Arkansas State Board of Health, discussed impending regulations relating to independent physician laboratories.
5. Received a report from Ken LaMastus on the Arkansas Health Care Access Foundation's Articles of Incorporation which were recently filed. Officers are: Drs. W. Ray Jouett, president, and Harold Hedges, secretary. Bylaws state that the majority of the board of directors must be physicians.
6. William Jones distributed an updated report on the AIDS Committee.
7. Received a report from Joe Verser outlining the actions taken by the AMA House of Delegates during the interim meeting in Dallas in December, 1988.
8. Approved a $1,000 donation to support the Auxiliary's DWI Video Contest.
9. Received a report from Ken LaMastus regarding the IRS audit of the AMS for the period ending December 1986. Only minor procedural changes will be made to meet IRS recommendations. No financial expense was incurred.
10. Received a report from Lloyd Langston, chairman of the Building Fund. The AMS building is 100% leased.
11. Received a report from James Weber, chairman of the Medical Legislation Committee, on the HMO legislation and incidents surrounding it. Dr. Weber asked that the council recognize Dr. and Mrs. W. Payton Kolb, Charles Rodgers, William Jones, and Lynn Zeno for their hard work since the beginning of the legislative session.
12. Received a brief status report from Lynn Zeno on pending medical legislation in the House and Senate.
13. Voted to forward a resolution presented by Dr. Ben Saltzman to the AMA supporting the elimination of TB.

The Council met on Sunday, July 23, 1989, at the Holiday Inn West in Little Rock, and the following business was transacted:

1. Received a report from David Harshfield on the AMA's Young Physicians Section meeting held during the AMA annual meeting.
2. Re-elected J. Larry Lawson as chairman of the council.
3. Elected R. Jerry Mann to complete the unexpired term as Eighth District Councilor vacated upon the election of William Jones as president-elect.
4. Approved the minutes from the annual session meetings, April 27th-29th.
5. Approved the May 24, 1989, Executive Committee minutes as follows:
   a. Appointed John Hestir to the Health Department's task force on infectious waste material.
   b. Charles Fitzgerald, David Smith, and Anthony Fletcher were appointed to the Medicaid Drug Formulary Committee of the Department of Human Services.
   c. Approved funding for two children to attend Med-Camp.
   d. Reviewed the annual session financial breakdown.
   e. Discussed legislation concerning tax credit for physicians practicing in underserved areas. This legislation was introduced by Senator Pryor. Directed a letter to be written to Senator Pryor thanking him for his efforts in supporting this legislation and ask that he look at amending the tax

credit for rural areas that have slightly less needy categories.

f. Approved travel for: 1) the Executive Committee to attend all AMA meetings; 2) Ken LaMastus to attend the AMA meeting in Chicago; and 3) two AMS staff members to attend the AMA meeting in Hawaii in December, 1989.

6. Approved the June 30, 1989, Executive Committee conference call minutes as follows:
   a. Approved travel for Ken LaMastus and Lynn Zeno to attend the AAMSE annual meeting in San Diego.
   b. Received an update on the recent trip to Washington that several members of the AMS made to visit with our congressional delegation.
   c. Supported the AMA's recommendation that Congressman Tommy Robinson receive the Davis Award.
   d. Recommended that the AMS staff continue its efforts, along with help from Senator Pryor, to stop expenditure target legislation.
7. Received an update from Mrs. J. Larry Lawson, AMS Auxiliary president, on their projects.
8. Received a report from Joe Verser, senior AMA delegate, on actions taken during the annual AMA House of Delegates meeting.
9. Received a report from Ron McGaugh, president of the AMS-MSS, on the AMA's Medical Student Section meeting.
10. Adopted the following recommendations of the Committee on Continuing Medical Education as follows: 1) increase the CME application fee to $250; 2) implement an annual fee of $100; and 3) increase the per diem for surveyors to $100.
11. Agreed to enter into an agreement with Tours and Travel, of Russellville, to recommend them to the Society members for their travel needs.
12. Lynn Zeno, director of Governmental Affairs, presented the amended portion of the Long Range Plan pertaining to the Department of Governmental Affairs. It was decided that Mr. Zeno would rewrite Section A, #3, to include more specific language and terms for members of the Governmental Affairs Council. It was decided that Section B, #1, would also be rewritten to clarify that members of the Steering Committee are also members of the GAC Council. These changes will be mailed to members of the council.
13. Ken LaMastus reported the target date of September 1, 1989, for implementing the indigent care program, Arkansas Health Care Access Foundation.
14. Received an update from William Jones, chairman of the AIDS Committee, on their continuing programs and the outcome of the AIDS resolutions supported by the AMS at the recent AMA House of Delegates.
15. Received a report from Glen Baker, chairman of the Annual Session Committee, on the attendance and budget of the annual session.
16. Reviewed the financial and membership reports for the period ending June 30, 1989.
17. Received a report from Chairman Lawson on the recent trip that he and several other AMS members made to Washington to visit the congressional delegation.
18. Approved a motion to form a committee, Concerned Physicians for Health Care for the Elderly, and 2) expedite a public relations campaign immediately pertaining to ETs.

The Council met on Sunday, November 19, 1989, at the Holiday Inn West in Little Rock, and the following business was transacted:

1. Approved the minutes of the July 23, 1989, Council meeting.
2. Approved the minutes of the September 27, 1989, Executive Committee conference call as follow
   a. In reference to a letter from Dr. James Mashburn, the Executive Committee recommended that the AMS inform the U. S. Public Health Service that the Pulaski County Coroner is not an M.D. Listings from this department indicates that Mr. Steve Nawojyzyk is an M.D.
   b. The Executive Committee recommended that a letter be written to Ralph M. Maxwell, D.O., president of the Arkansas Osteopathic Association that indicates the Society views D.O.'s the same way they do M.D.'s and that any D.O. is eligible to be appointed to the Medical Board.
   c. Reviewed the membership benefits of the U. S. Chamber of Commerce.
   d. Approved the following individuals for dues exempt status: Clarence E. Gossett, Donald J. Kroe, and Barrett Sparks, Craighead/Poinsett County; James C. McMahan, Garland County; Robert S. McGinnis Sr., Miller County; Samuel B. Caruthers Jr., and Joseph P. Hickey, Pulaski County; and Don M. Meador, Sebastian County.
3. Approved the minutes of the October 25, 1989, Executive Committee meeting as follows:
   a. In reference to a letter from the Department of Human Services, the Executive Committee directed a letter be written to DHS indicating we also favor closer communications.
   b. Received a brief report on the special legislative session.
   c. Ken LaMastus reported that he has been invited to serve on the Loss Prevention Committee of State Volunteer Mutual Insurance Company.
   d. Received a report on the Arkansas Academy of Pediatric's interest in obtaining services that the AMS provides to specialty groups.

e. Discussed forming an ad hoc committee that would revise the AMS Constitution and present it to the 1990 House of Delegates.
f. Discussed the appropriateness of appointing a group to study the possibility of establishing a private pension plan similar to the one that South Carolina has that would cover only physicians.

4. Discussed the Cash Budget and Membership Reports for the period ending October 1989.
5. Discussed the proposed rules and regulations pertaining to the management of special waste with Mary Ann Coleman, Arkansas Department of Health.
6. Received a report from Robert Langston on the Boone County legislative rally held August 24, 1989, and an anatomy of a local successful governmental affairs committee.
7. Received a report from Mrs. J. Larry Lawson, AMS Auxiliary president, on the current activities of the Auxiliary.
8. Received a report from Mrs. Robert Powers, president of the Pulaski County Medical Society Auxiliary, regarding a booklet their auxiliary published entitled, "For Your Information".
9. Received a report from Ken LaMastus on the indigent care program. Pat Keller, director of the Arkansas Health Care Access Foundation was introduced.
10. Instructed the delegates and alternate delegates to the AMA to vote for the Board of Trustees Report X (without modification or amendment that might weaken its impact) at the 1989 interim meeting .
11. Received a report from Morton Wilson outlining changes that have taken place at the AFMC. Dr. Wilson stressed that one of their objectives is to re-establish a good working relationship with the AMS and physicians throughout the state.
12. Approved the discount pricing offered on Sharp fax machines as an AMS membership benefit.
13. Recommended that Blue Cross review their reimbursement to physicians who serve on the MSRC Committee and consider compensating these physicians for travel time.
14. Recommended that the new coalition subcommittee give an update of their activities at the next council meeting.
15. Joe Verser requested attendance at a public hearing concerning proposed regulations on post-operative care December 14th.
16. Received an update from Mike Mitchell, AMS general counsel, outlining the workers' compensation lawsuit, "Coleman vs. Holiday Inn", whereby a portion of the attorney fees come from health care providers. This was ruled a violation of Arkansas law. A coalition of the Arkansas Medical Society, Arkansas Hospital Association, Arkansas Physical Therapy Association, Arkansas Chiropractic Association, Arkansas Podiatry Association, and the Arkansas State Dental Association was formed to file an amicus curae brief pertaining to this suit.
20. Appointed Paul Wallick to the Budget Committee for a three-year term beginning January 1, 1990 through December 31, 1993.

Fifth Councilor District
Cal R. Sanders, M.D., Senior Councilor

A Fifth Councilor District meeting was conducted in El Dorado on January 17, 1990. Lynn Zeno, AMS director of Governmental Affairs, presented a program on current legislative and regulatory issues affecting the medical profession. Among the topics addressed were: Workers' Compensation Commission rulings; efforts to increase Medicaid and Medicare expenditures; and quality of care issues. Mr. Zeno also presented survey information showing the high cost of health care as the number one concern of Arkansas employers of 50 or more persons. AMS President-elect, William N. Jones, M.D., was a guest at the meeting.

Officers elected for the Fifth Councilor District were John E. Alexander, M.D., Magnolia, president; Bert Dougherty, El Dorado, secretary/treasurer; and Cal R. Sanders, M.D., Camden, councilor.

Eighth Councilor District
Charles Logan, M.D., Senior Councilor

The Eighth Councilor District (Pulaski County) was engaged in numerous activities during 1989. A brief summary of the most significant of these is presented here.

A resolution was adopted urging the Arkansas Medical Society to seek legislation that would prohibit the mandatory substitution of name brand drugs with generic drugs.

Four membership meetings were held. The speakers and their respective topics were: Joycelyn Elders, M.D., "School-based Health Clinics"; Chris Hackler, Ph.D., "Medical Ethics"; James R. Weber, M.D., "Current Legislative Issues and Physician Reimbursement"; and Mr. Robert Shoptaw, vice president of Arkansas Blue Cross Blue Shield, "Health Care Trends and Managed Care Programs".

A contribution was made in the amount of $2,000 to the Pulaski Medical Society Auxiliary's Adolescent Health Project, a pocket-size resource referral booklet for teens entitled, "For Your Information". A contribution was also made to Med-Camps of Arkansas to underwrite the cost of camp attendance for two children.

A $5,400 scholarship was awarded to an entering freshman at the University of Arkansas College of Medicine.

Two health care programs were formally endorsed,

the Visiting Nurses Association of Arkansas and the Jefferson Comprehensive Care Center. These endorsements helped secure funding for these organizations.

Additionally, the district continued its administrative support of the Senior Physicians of Arkansas organization.

Ninth Councilor District
David L. Rogers, M.D., Senior Councilor

Physicians in the Ninth Councilor District continued to be very politically active in 1989. Doctors in Boone County played an important role in organizing physicians throughout the state to attend the board meeting of the AFMC early in the year. The state's PRO had been under heavy criticism by physicians in Arkansas, and at that meeting AFMC members voted in a new slate of board members and officers. A lot of credit belongs to the physicians in Boone County.

In August, the physicians in Boone County held their annual fish-fry. Among the 110 guests present were all of the area legislators, Representative John Paul Hammerschmidt, and various local elected officials and civic leaders. This event has become a very popular political and social event for the Boone County medical community.

The Washington County Medical Society held the Third Annual Legislative Appreciation Dinner in October. The dinner was kicked off with a golf tournament at the Fayetteville Country Club. Twenty-eight golfers, including State Representative Bob Fairchild, played in the scramble tournament with prizes given for the winning team, longest drive, and closest to the pin. Physicians and their spouses joined area legislators and their wives for a prime rib dinner that evening.

We anticipate a continued interest in medical politics from the physicians in the district who continue to be some of the most politically active doctors in the state.

Tenth Councilor District
Morton C. Wilson, M.D., Senior Councilor

The Tenth Councilor District has been active both politically and in scientific endeavors. The Polk County Medical Society has had two general membership meetings. Dr. Eleanor Lipsmeyer spoke to the physicians on "Reiter's Syndrome". Mr. Lynn Zeno addressed the Society in the fall of 1989 on "Political Update". A similar presentation is planned for the combined meeting of the Sebastian County Medical Society and Auxiliary in January.

Dr. Richard Pearson, vice chairman of the board of directors of the Arkansas Foundation for Medical Care, addressed the Yell County Medical Society on "The PRO Third Scope of Work". Dr. David Busby, medical director of the AFMC, has addressed several county medical societies in the Tenth Councilor District on the same topic.

Dr. and Mrs. John Swicegood held a fund-raising gathering at their residence in Fort Smith. This was well attended by local politicians, members of the Sebastian County Medical Society, and their wives.

Local physicians in each of the component county societies have been active in presenting educational programs concerning AIDS to their local school systems. Dr. Mark Stillwell conducted a teaching session on AIDS to the AHEC program in Fort Smith.

Executive Vice President's Report
Ken LaMastus, CAE

The only thing constant is change. This is true both with an organization and an industry.

Some of the changes occurring within the Arkansas Medical Society, and its accomplishments, in 1989 were the changes in the 1989 Annual Convention format in an attempt to make the convention more appealing to the broad spectrum of physicians. The convention was extremely successful. We received many compliments from members on the educational programs and the general organization of the shorter format.

After two years of work and planning, the Arkansas Health Care Access Foundation was established and began operation in September 1989. Since that time, over half the pharmacies in the state have agreed to participate, over half of the home-health agencies in the state, and almost 900 physicians agreed to provide some level of services to people who were below the poverty level but had no form of health insurance. By the end of December, over 500 referrals had been made to physicians in the state. The Foundation represents the commitment of Arkansas physicians and the Arkansas Medical Society as well as other health care professionals to provide many people who could not afford health care services some of the assistance they need.

During 1989, a landmark process took place in the Arkansas Medical Society. The House of Delegates approved a long-range plan that should carry the Society well into the next century. The 1990 session of the House of Delegates will see and consider a revision in the Constitution and Bylaws. It is being completely rewritten and, as is required under the current Constitution, must be reviewed at the 1990 Annual Session to be considered for final passage in 1991.

This year brought some changes in personnel within the office. Cindy Logan, executive secretary, moved to Chicago with her husband who was transferred. Martha Taylor, who had done outstanding work as managing

editor of the *Journal of the Arkansas Medical Society* and was responsible for the conversion to the Desk Top Publishing System, was offered a position with a local environmental firm. We do very much appreciate the contribution that Martha made to the Medical Society and to the *Journal.*

Cindy Williams is the new executive secretary. She was formerly employed in a similar position with the Mississippi Manufacturers Association. Stephanie Percefull is the new managing editor of the *Journal.* She comes to the Society from the Arkansas Bankers Association where she worked with their magazine.

Last year saw changes in the Arkansas Foundation for Medical Care (PRO). The AFMC was originally organized by the Arkansas Medical Society but it is a separate corporation with a separate board. In the last few years many physicians had complaints about how the organization had conducted its utilization review functions for Medicare, Medicaid, and private review. Because of the efforts of several physicians in the state, changes were made in the management of the organization which will hopefully bring about a better rapport between the practicing physicians and the organization.

The Arkansas Foundation for Medical Care leadership has been making asserted efforts to inform all physicians about the job the PRO must do and to open up the organization by encouraging physicians to attend all meetings that are not required to be closed by statute or regulation. The Foundation should be commended for improving communications and encouraging participation from a broader range of physicians in their work and deliberations.

During the last legislative session, one landmark law was enacted through the efforts of the Society. Arkansas is only the second state in the nation to attempt to place some regulations on third party organizations doing so called "peer review." These organizations are attempting to hold down the cost of health care by pre-admission and pre-procedural authorization. In many cases, physicians were being harassed in the hopes they would not provide services to their patients.

The new regulations which are in the process of being developed puts the responsibility of reviewing these organizations within the Arkansas Department of Health. Hopefully, this relieves some of the physician aggravation over some of the ridiculous and harassing tactics being used by these organizations.

The entire health care industry is under more and more criticism because of the increasing costs of health care services in general. These criticisms have brought forth many changes in the delivery of medical care, including cut-backs in funding for various programs such as Medicare and Medicaid. No doubt these efforts both by the government and private organizations will continue as the cost of health care approaches 12% of the value of all goods and services produced in this country (GNP).

Governmental Affairs Committee
Charles Rodgers, M.D., Chairman

With the increasing intervention of government into the practice of medicine, the activities of the Governmental Affairs Committee continue to grow.

1989 started with an active session of the Arkansas Legislature with more than 100 medical related bills being considered. The AMS enjoyed almost 100% successs in the House of Representatives and suffered the expected set-backs in the Senate Judiciary Committee. We were successful in passing several bills that will benefit the practice of medicine and we defeated several bills that were detrimental or costly to our practices. The first annual "Day at the Capitol" program was conducted with approximately 150 physicians and spouses attending a legislative briefing followed by visits to the Capitol, and a legislative reception was held with more than 200 persons in attendance. Thanks to Lynn Zeno and staff, the "Day at the Capitol" was a tremendous success and should be repeated each session.

Under the direction of lobbyist Lynn Zeno, the AMS worked to strengthen our relationship with other health care providers who share mutual concerns. Mr. Zeno maintained an active speaking schedule with the county societies, specialty groups, medical assistants, clinic managers, and members of the AMS Auxiliary. Our goal is to involve all of these people in our grass-roots political efforts.

The need for political involvement is not only necessary during the legislative sessions, but there is an increasing amount of activity in the off season. The AMS is actively involved with regulatory agencies in the drafting of rules regarding laboratory regulations, infectious waste, and the requirements for third-party payor utilization review organizations.

The Governmental Affairs Committee is closely monitoring current litigation involving medical practices. Our legal counsel is analyzing the effect of a Russellville lawsuit regarding the patient's right to assign insurance benefits directly to the providers and we have filed amicus curae briefs to overturn a Workers' Compensation Commission ruling which requires physicians to pay the legal expenses of certain injured patients they treat.

As the campaign season approaches, the Governmental Affairs Committee will solicit PAC funds for the support of candidates friendly to medicine. Contributions are based upon recommendations of physicians contributing to PAC; an incumbent's voting record and past support of medical legislation; and an analysis of previous election returns, voting records, and political polls assessing a candidate's electability.

This past year, the Governmental Affairs Committee maintained a significant role in national legislation. In June, seven AMS physicians representing a variety of specialties and each of the congressional districts went to Washington and met with our congressmen to discuss the

proposed Budget Reconciliation Act. This delegation of medical doctors also met with the staff of the Senate Special Committee on Aging to discuss Medicare problems.

In July, AMS director of Governmental Affairs, Lynn Zeno, and I made an emergency trip to meet with Senator Pryor on the evening prior to a significant vote regarding expenditure targets and the Medicare budget. The meeting proved fruitful in that Senator Pryor supported our position.

In October, AMS representatives from each congressional district journeyed to Washington to attend the Bi-Annual AMPAC Conference to discuss political fundraising and strategy. The AMS also provided testimony for the "Pepper Committee" hearing in August concerning needs for the elderly.

Recently, Mr. Zeno and five AMS members representing all congressional districts met with our senators and representatives at their respective offices in Washington, D.C. The purpose of the meeting was to improve our communicative efforts with the congressmen and their staff. A reception was held for the Arkansas delegation in the Rayburn Building and we had good dialogue with the staff of the congressmen. We hope we made an impression with our congressmen about the unfair Medicare reimbursement schedule for Arkansas as compared to surrounding states.

Since the creation of the Department of Governmental Affairs in 1988, the AMS has experienced a significant increase in political, legislative, and regulatory activity. This increased exposure is being recognized by the membership and is having a noticeable impact on our successes in the political arena.

The Legislative and PAC Committees wish to thank all the AMS members and spouses who contributed money and time to making this a successful year. We are getting better at being politicians, which is a necessity for our survival.

We give special thanks to Lynn Zeno and his staff for the outstanding job they are doing.

Report on the Indigent Care Program
Ken LaMastus, CAE, Executive Vice President

The Indigent Care Program, which was approved by the House of Delegates, began operations in mid-September of 1989. It was organized in an attempt to provide some level of health care services to those people who are below the poverty level but not eligible for Medicaid.

Arkansas Health Care Access Foundation, a non-profit foundation, was established to perform this function and was funded by the state of Arkansas through its Indigent Care Task Force at the level of $112,000 for the first year of operation and approximately $88,000 for the second year of operation. From its beginning until the end of January 1990, 820 referrals have been made. The total number of eligible people through the end of January was 5,217. There are 848 physicians who have volunteered their services along with 72 home health agencies, plus the Arkansas Department of Health's home agencies and 341 pharmacists. Pharmacists were in their component of operation at the first of the year.

The only other program like this is in the state of Kentucky and it was organized by the Kentucky Medical Association. The Arkansas program is more comprehensive than Kentucky's because it includes home health agencies and pharmacists. This makes the Arkansas program the most comprehensive of this type in the nation.

The Foundation has a statewide telephone number where people can obtain information as well as get referrals. First, they must receive certification by a county human service office that they are below the poverty level, and that they have no form of health insurance.

This program proves the commitment of Arkansas physicians and other professionals by trying to be of assistance to those whose income may prevent access to medical care.

According to the bylaws, the board majority is made up of physicians with representation from the other health care groups. The board officers are Dr. W. Ray Jouett, president; and Dr. Harold Hedges, secretary/treasurer. Other physicians on the board include Drs. Asa Crow, Lloyd Langston, John P. Burge, John M. Hestir, Gilbert A. Buchanan, and James D. Armstrong; all the physician board members are appointed by the president of the Society. Other board members include Tom Tapp, representing the Arkansas Pharmacy Association; Jim Teeter, representing the Arkansas Hospital Association; and Madge Helm, representing the Arkansas Association of Home Health Agencies. Don Steely represents the Arkansas Medical Society Medical Student Section.

Ken LaMastus is executive vice president (with no compensation), Pat Kellar, LSW, LPN, is director, and Susan Rish is her assistant.

Insurance Committee
Eugene F. Still, II, M.D., Chairman

The insuring of the state society members for long and short term disability has continued above our highest projections. Continued monitoring of the insurance market has assured us that we are, at present, getting the best value for our dollar and we have been able to offer to all insured under the old plan, continued coverage under the new plan.

At present, we are investigating new markets which include retirement benefit programs and life insurance programs. These will be developed as has been the disability program, to attempt to assure the membership the highest quality product for the lowest cost.

Committee on Maternal and Child Health
Deborah Bryant, M.D., Chairman

Arkansas Medical Society representatives were appointed to serve on several maternal and child health advisory panels this year.

Jerry Morgan, M.D., represents the Society on the Governor's Perinatal Advisory Board. The board, authorized under Act 159 of 1979, was reactivated in February 1989, to recommend to the Governor and General Assembly necessary improvements in obstetric and neonatal care in the state. Discussions have centered on strategies to improve access to care for indigent pregnant women and to lower women's risks through patient education. A report to the Governor is being prepared in anticipation of the next legislative biennium. Drs. Frank Miller, Bob Fiser, Steve Marks, and Deborah Bryant also serve on the committee as representatives of the Departments of Obstetrics and Gynecology and of Pediatrics, the Arkansas Chapter of the American College of Obstetrics and Gynecology, and the Department of Health respectively.

Pulaski County hospitals, perinatal providers, the Department of Health, and Arkansas Medical Society are collaborating in an infant mortality review funded by the DHHS. This project will provide a multi-disciplinary review of infant deaths in Pulaski County in a one-year period to determine the medical, social, economic, and behavioral team, nominated by the Society and appointed by the Board of Health, will review these risk factors and develop intervention strategies to reduce the number of infant deaths in Pulaski County. It is hoped that a successful review team model can be implemented in other interested communities.

Representatives of the Society, Academy of Family Physicians, American College of Obstetrics and Gynecology, Department of Obstetrics and Gynecology, and Department of Health have formed an ad hoc obstetric subcommittee to the Medicaid Advisory Committee. The group, formed to respond to concerns of the Medicaid utilization review staff over high caesarian delivery rates among Medicaid patients, met in January 1990, to develop recommendations for the Advisory Board. Society members Hoy Speer and Deborah Bryant, members of the Advisory Board, are co-chairing the committee.

Medical Service Review Committee
Charles H. Rodgers, M.D., Chairman

The purpose of the Medical Services Review Committee is to serve the patients of the state of Arkansas by insuring proper utilization review and quality assurance of selected cases of Blue Cross Blue Shield and Medicare claims. The membership is decided by the council of the Arkansas Medical Society and represents the different specialties of the Society.

There were six meetings of the MSRC in 1989 and 80 cases were reviewed in depth with appropriate recommendations made to BC/BS. There were three personal appearances by physicians wishing to express their viewpoints about difficult cases that they may or may not have been involved with.

I would like to express my appreciation to all the members of the MSRC, Dr. Bob Benafield, and the staff of BC/BS for their hard work and enthusiastic support.

Pension Plan Trustees
John M. Hestir, M.D., Chairman

The Pension Plan Trustees of the Arkansas Medical Society's Employees' Pension Plan have received by mail a report on the pension plan earnings through the third quarter of 1989. They were 16.24%.

As of this report, the year-end report for 1989 has not been received.

There have been no changes in the pension plan during 1989. The Pension Plan Trustees have not had a formal meeting. As mentioned previously, they have reviewed the earnings report from Worthen Bank, who manages the plan. The plan continues, as it has for several years, to be one of a defined contribution. The plan was changed several years ago. It is one in which the plan cannot be in arrears, as to funding, unless contributions are not made in the given period of time.

Contributions to the plan are made on a monthly basis with checks being written to Worthen Bank. Employees receive an annual report of their vested interest in the plan. This is done by a report from Worthen Bank mailed to the Medical Society. The information on this is provided to the Pension Plan Trustees and all employees.

I would like to thank the other member who served as trustees. They are Drs. James F. Kyser, Joe H. Stallings, Thomas H. Hollis, and James M. Kolb, treasurer of the Society.

Physicians' Health Committee
Joe L. Martindale, M.D., Chairman

Since it's reorganization in 1987, the Physicians' Health Committee has developed significantly. In 1989, we established a good working relationship with the State Medical Board, added two members to our committee, and had five physicians who completed inpatient treatment were added to the list of those being monitored, bringing the total number to over 25. Because of the committee's existence and its work, several other physicians entered into the Alcoholics Anonymous program as a self help recovery program and are doing very well. Three physicians in the state were investigated by the committee but no basis for intervention was found.

In 1989, St. Paul Insurance Company donated to the

Physicians' Health Committee $26,682 in unclaimed dividends by physicians to be used to further the work of the committee. (In reality, it was monies donated by physicians to help physicians). The plans for these funds as well as the long range plans for the committee and its operations are listed below.

The committee's immediate goal and means of funding this goal is as follows:

1. Propose that we contract with a person who is familiar with chemical dependency and who has a definite interest in recovery.
2. Hire her for one day per week at a cost of $7,500 per year.
3. Provide her with AMS phone access and travel expenses should the need arise.
4. Her duties would be to develop a record keeping system, follow up on complaints, correspond with the impaired physicians, and other persons who may need access to information.
5. Work closely and directly under the direction of the committee. Any and all action and decisions will be made by the committee.
6. To use monies donated by St. Paul Insurance Company at the rate of approximately $10,000 per year to fund such person. We estimate current funding for two and one-half.

It is the long range plan of the Physicians' Health Committee to employ a physician, a medical director, and an executive assistant (a person knowledgeable in the area of chemical dependency) to monitor and maintain personal contacts on a regular and more efficient basis. This would obviously require ongoing funding! A method to achieve additional funding without taking monies from the general operating account and without proposing an additional dues increase is for each physician to voluntarily contribute $25 per year to the operation of the committee.

The work of the committee is important and we would like the entire medical community to be a part of our work. We, as a committee, are willing to take time from our practices and absorb our own travel expenses to help our fellows. But, as the numbers grow, it will become increasingly more difficult for us to do this without your help.

If we are to have a top-notch program in Arkansas, we need your financial support. My feeling is that we have progressed too far in making a difference in the lives of many of your colleagues to turn back now, especially in a time when the problem is becoming larger and larger.

Position Papers Committee
James M. Kolb, Jr., M.D., Chairman

The Committee on Position Papers met and developed the following paper, Financial Policy of the Arkansas Medical Society.

The committee has also reviewed papers that were previously developed for their timeliness due to the changing environment of medicine.

I would like to personally thank the other members of the committee. They are Drs. W. Payton Kolb, George Warren, Lloyd Langston, Paul Cornell, Jim English, Lee Forestiere, and J. David Busby.

Financial Policy of the Arkansas Medical Society

The Arkansas Medical Society should at all times work to maintain the most efficient use of Society assets. At various times during the year, the Society has funds in excess of those needed to operate for a given period of time. This is because dues are collected primarily in the first quarter, whereas Society expenses are spread more evenly throughout the year. In addition, the Society maintains reserve funds accumulated over time from years in which Society revenues exceeded expenses.

For the purpose of this document, *operating funds* are defined as those funds necessary to pay the expenses of the Medical Society for a given year. *Committed reserves* are those reserve funds set aside for a specific purpose, for example, funds are being set aside to purchase the Arkansas Medical Society building. *Unrestricted reserves* are defined as those reserve funds not committed to a specific purpose or long range project.

The management of *operating funds* should be to provide enough liquidity to cover the Society's expenses, while maximizing interest earnings. Operating funds should be maintained in short-term deposits or money market accounts while coordinating the maturity of longer term investments to coincide with the time funds are needed. The funds would be invested in short-term certificates of deposit or federal government securities of a short-term nature. Those funds necessary for immediate operation should be maintained in accounts that allow for check writing such as a "ready asset" account that normally pays interest but at a lower amount.

The management of *committed reserves* should be such as to maximize the interest rate while preserving capital. The Arkansas Medical Society should invest it's funds in insured C.D.'s, government issues, and insured or government backed securities. Because of it's long-term nature, committed reserves may allow investment in corporate bonds. They should be those having a high quality rating. Since the Arkansas Medical Society is a tax exempt organization there is no advantage in investing in tax free obligations.

The management of funds for the association should have some basic ground rules as to what constitutes adequate *unrestricted reserves.* The Arkansas Medical

Society should consider prudent, conservative goals of maintaining a minimum of six months to one year operating capital in unrestricted reserves. This policy gives the Society the security of knowing funds are available for emergency needs, and unforeseen circumstances that may require significant levels of money. It should be noted that the Society receives interest earnings from these funds.

The Arkansas Medical Society's operating fund should require two signatures on all checks to insure safety. The Society should undergo an independent audit at least annually. The Budget Committee should periodically review the status of investments and assume the responsibility of establishing investment strategy and policies. From time to time the staff of the Arkansas Medical Society and/or the Budget Committee should review, with professional money managers or financial institutions, the most advantageous investment policies.

Professional Relations Committee
Eighth Councilor District
Charles H. Rodgers, M.D. Chairman

The committee reviewed several complaints from patients and perceived mistreatment by physicians in this district. The majority of the cases appear to be communication problems between physicians and several were solved by further communication clarifying their differences.

The Professional Relations Committee believes there would be fewer complaints and, perhaps, fewer lawsuits if physicians better communicated with their patients. In fact, some of the involved physicians failed to respond to our inquiries about complaints they were getting from their patients.

This committee does not decide treatment outcome and makes no judgement as to whether malpractice is an issue in these cases. We are merely a public relations committee.

State Legislative Fund
Charles Rodgers, M.D., Chairman

1989 was a non-election year and the AMS did not conduct a general solicitation for the State Legislative Fund. There were, however, a significant number of members who made contributions. Because of extensive political activity on the national level, the emphasis in 1989 was on AMS-PAC (federal) solicitation.

The AMS Long Range Planning Committee did an extensive review of our campaign fund-raising activities and elected to combine the solicitation of contributions for both state and federal offices into one PAC. This new process will permit easier billing, reduce record keeping, and ease the confusion on the part of members about which fund they have or have not contributed to. Under the new PAC proposal, the dollars collected will be divided between the state and national candidates unless the contributor request otherwise.

The State Legislative Fund distributed $6,200 in campaign contributions in 1989, however, the need for campaign expenditures will increase tremendously during the election year, 1990.

I would like to express my appreciation to Mr. Lynn Zeno for preparation of this report.

Contributors to the State Legislative Fund (1989)

Arkansas
* Hoy B. Speer, Jr.

Baxter
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Crawford
Douglas Parker

Drew
* Paul A. Wallick

Garland
Bruce L. Smith, Jr.

Greene/Clay
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* Contributed $100.00 or more

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Taylor A. Prewitt
* R. Wendell Ross
John R. Swicegood

Union
Kenneth R. Duzan
* Diana Jucas
* George Warren

Washington
C. Stanley Applegate, Jr.
David A. Davis
* G. Glenn Fincher
Ted J. Fish
Morriss M. Henry
* James E. McDonald, II
* Mrs. James E. McDonald, II
William M. McGowan
* Danny L. Proffitt
* Earl B. Riddick, Jr.

White
* John C. Henderson
J. Garrett Kinley
* Robert D. Lowery
* Larry W. Weathers

Yell
* James O. Pennington
Gene D. Ring

* Sustaining members (contributed $99.00 or more)

Young Physicians Committee
David Harshfield, M.D., Chairman

The Young Physicians Committee has been active on both a state and national basis - on a state level through our committee activities and, nationally through the American Medical Association Young Physicians Section (AMA-YPS). I was privileged to have been asked to serve as chairman of one of the AMA-YPS Reference Committees during the December 1989 meeting in Honolulu. In addition, the Arkansas Medical Society has clearly shown its commitment to the young physicians through several important committee appointments. This report will outline our activities both on a state and national level since the two are inextricably intertwined.

The December meeting of the AMA-YPS was probably our most important meeting to date. Over the last several years, since the inception of the AMA-YPS, our main thrust has been obtaining members and becoming organized as a functional, useful entity within the Section as a distinct and credible division of the AMA. It is becoming apparent to all of us that our imminent responsibility is now establishing short-range and long-range goals for this Section, accepting the fact that our organizational efforts have been successful.

What is to follow will be a formulation of the ideas representative of the work through reference committees and discussion groups with other young physicians across the country. Much of the content will, unavoidably, represent a blend of information which has been derived from those communications with others, as well as, opinions which I have personally formulated over the last few years in regards to these important issues.

Much of the discussion at each AMA-YPS assembly pertained to acute problems on the national and local levels in regards to the practice of medicine, the government intervention into that practice, and the perception by the public of our profession. For instance, at the 1989 AMA interim meeting, the topic of discussion was Dr. James H. Sammons' status as executive vice president. At the annual meeting in Chicago, the chief topic of discussion centered around expenditure targets. In all sections of the AMA, these topics were thoroughly discussed and thus I will try not to reiterate that information. What I would like to do, however, is to present the basic underlying current thought in regards to the practice of medicine in the opinion of young physicians and to present major aspects of the developing philosophy in this subset of physicians.

Some of our chief concerns center around problems which may seem unique to young physicians and, therefore, unduly self-serving. And though some of these unique concerns may not appear to be of immediate importance, I hope to explain how they are basic to the formulation of the philosophy we all must develop as physicians irrespective of our age groups, specialties, or regional differences. The more important aspects of this philosophy take into account those ideas which may be beneficial not just to members of the AMA, and not to just physicians as a whole, but in a broader sense beneficial to society. As honest and ethical as physicians want to appear, to many in society on the outside looking in, we are merely a self-serving group of professionals not unlike the lawyers or entrepreneurial businessmen.

Much of the efforts of the AMA-YPS have been aimed at organizational tasks which are in a broad sense self-serving and not specifically beneficial to society or even the AMA for that matter, on the short run. However, the development and organization of this group of physicians in the long run will, without question, be a positive accomplishment in many respects.

First of all, most young physicians previously were not involved either politically, or in many cases, professionally with the AMA. I think that it has become apparent from the lessons learned by dealing with the chiropractors and optometrists that organization and unification are the keys to maintaining the integrity of any profession. Probably the beginnings of the AMA-YPS were simply to increase the membership of the AMA by obtaining younger doctors and allowing them the attractiveness of having their own section. The response has been overwhelming and the general body of the AMA has benefited from the efforts of this budding new division. I don't think there is a single member of the AMA-YPS who would consider our division as being a separation from the AMA or that its formulation was due to dissatisfaction with the policies of the AMA governing body. In fact, the AMA-YPS feels as though it has become a well-respected division of the AMA, which is highly supportive of the actions of the House of Delegates. We are learning at an early stage of our careers, that through parliamentary procedure we have the ability to change the course of medicine by hard work and appropriate political involvement, to have the voice of this segment of physicians heard in a constructive and positive manner in alliance with the AMA governing body.

As chairman of Reference Committee A at the 1989 interim AMA-YPS assembly, I had the privilege of assuming a leadership role in the preparation of issues presented in the House of Delegates. One of the important issues of the AMA-YPS assembly is the need to educate the public as to facts pertaining to current problems in health care.

The AMA-YPS realizes, as do most members of the medical profession, that public perception will have a great deal to do with the outcome of the current turmoil concerning the practice of medicine in this country. We have become very active in the last few years, mainly in the areas of patient education and combating media misinformation campaigns which have been ongoing in regards to development of a National Health Care System.

At the last AMS meeting, the Young Physicians Committee had three resolutions passed. One of those

resolutions specifically pertained to the somewhat inactive Physicians' Speakers Bureau, a service provided by the AMS, but not utilized by many around the state. Through combining the Speakers Bureau with the Science Ambassador Project (a thrust at helping to organize physicians to speak at schools and community functions) we succeeded in several areas. It is no secret that the applications to medical schools and to universities for degrees in mathematics and science have markedly diminished. Through the Science Ambassador Foundation, with cooperation of the Speakers Bureau, we are organizing presentations to young people who are at impressionable stages of their education to encourage them to seek careers in these areas. For example, this spring there will be a medicine/scientist section during the three-day meeting of the Hugh O'Brien Youth Foundation meeting in Little Rock. The Hugh O'Brien Youth Foundation takes the top tenth grader from each high school in the state and brings them to Little Rock for three solid days of dialogue and activities with some of the state's top political, business, and law figures. In its several year history in Arkansas, there has never been a panel of physicians or scientists to speak to these young kids who are at the impressible age in making career choices. On April 28th, a panel consisting of five outstanding physicians in the state will speak to these youngsters and answer questions concerning possible careers in medicine or science related fields.

In further regards to providing patient information and education, the Channel 7 Health Exposition which is held each year is one of many excellent forums in which physicians can participate. We have provided free carotid doppler screening the last two years and have been overwhelmed by the favorable response. It is apparent, that although financial support is an excellent way for physicians to give back to a community, an even stronger method is giving of their time and energy. We have learned from the experiences of the Speakers Bureau and Science Ambassador Project that establishing community relations is one of the most important things we as physicians can do to regain the respect and support of society. Many physicians have already become involved in community relations efforts. These efforts may include speaking at local women's clubs or taking part in community health fairs.

The following are some helpful suggestions which apply to any physician's community relations efforts. The big difference between the media and community relations is that in community relations you have direct contact with the public. The media is no longer a buffer between the physician and the public, so it is even more important to express one's self in a professional, friendly manner.

Some of the community relation efforts might include a hospital or group newsletter. This newsletter can be written in an easy to understand style and can be distributed to the surrounding communities. Including success stories, such as patients cured of cancer or any new service that may be offered, is important in making a publication interesting, as well as educational. Including a contact person's name, address and telephone number should be highlighted in this newsletter.

Physicians may be invited to speak or may want to call local groups to suggest a topic and potential speakers. During these presentations, research has shown that slides should be used only as examples, remembering that slides tend to separate the presenter from the audience and this may diffuse the purpose of the effort which is to build a closer relationship between the physician and the community.

It is always good to give your audience something to take home. A patient information pamphlet can be presented. Also, members of the audience may have questions they may want to ask you at a later date so it is important to provide them with a pamphlet or other written material which has your name, address, and phone number clearly indicated.

A physician's group may also want to sponsor a health fair where the public is invited to meet doctors and other health care professionals. Also, physicians may be asked to speak to local schools or set up a booth during the school's Career Day to explain the role of physicians in society. Whatever public relation efforts we decide to undertake, we should remember that touching our audience is our goal. Our preparations are the key to success of any public relations effort. Our goal is to encourage goodwill, be professional, yet personal.

The AMA-YPS is certainly not unique in its concerns over the current tort system of resolving medical malpractice cases. The AMA-YPS has, on a national level, been instrumental in supporting the incorporation of the current Georgetown Project, which is providing test sites in five states for the establishment of a fault-based system. In this type of system, malpractice or maloccurrence cases are heard by a board derived from the state medical board and/or representatives from other legislative factions, which would hear cases and make disposition outside of the current court system. In this fault-based system, there is an uncoupling of the adversarial and unnatural combinations of a) our patients with their lawyers, and b) physicians with malpractice insurance companies. Instead, we as physicians become patient advocates presenting cases where our patients have suffered an untoward outcome or maloccurrence and, based on our presentations, relying on the board to determine appropriate awards to the patients with no court costs or attorneys' fees. Our closest neighbor in this regard would be Mississippi who is participating in this project. A resolution from the Young Physicians Committee to the AMS at the spring meeting will ask an appropriate existing committee to closely monitor the progress of the Georgetown Project and to report back their findings.

Several other resolutions will be presented from the

Young Physicians Committee at the AMS meeting in the spring. In addition to the request to monitor the progress of tort reform around the country, a resolution will be presented from the Young Physicians Committee to support the AMS in actively and aggressively pursuing appeal of a precedent setting decision in which attorneys could be awarded a portion of physicians' fees in successful workers' compensation cases. The Young Physicians Committee will also present a resolution commending the AMS for the Arkansas Health Care Access Foundation which is a statewide effort supported by physicians to address the dilemma of indigent or uninsured patients, and recommend that efforts such as these be made public along with details of future programs to be undertaken by the physicians of this state to reaffirm our recognition of and continued efforts to resolve these problems.

With AIDS being unquestionably one of the greatest health concerns facing both patients and physicians, the Young Physicians Committee will present a resolution asking the AMS Committee on AIDS to begin an aggressive approach in determining the institutional indemnification of health care workers and responsibility of disability and health insurance companies pertaining to AIDS contracted as a result of patient contact. As the initial cases of health care worker's contracting HIV from patient contact become reported, it has been noted that those workers health insurance companies and institutions where they contracted the virus have uniformly attempted to refuse indemnification responsibilities. We should take a leadership role to ensure medical and personal support for those of us who will contract this disease while providing medical care to our patients.

Concerning better physician organization, the Young Physicians Committee passed a resolution last year to have the AMS study dues in regards to quarterly or installment payments. Also, we wanted to study what effects increasing dues have had on membership and, therefore, on the overall unification of physicians. The Young Physicians Committee is set to become rededicated to increasing our membership in an upcoming statewide membership effort.

I think it can be easily determined from this report that the desires, goals, and philosophies of the Young Physicians Section are not unlike those of the entire AMA and AMS. Although there are problems which may seem on the surface unique to younger physicians, when closely analyzed they are almost universally problems which are of concern to all physicians no matter what age or specialty. The Young Physicians Section, on a national level, has been holding leadership conferences in which the short, intermediate, and long-range goals of the sections are being determined. This will be presented at the 1990 AMA annual meeting in Chicago and I will report these findings to the AMS.

On behalf of the Young Physicians Committee and all the young physicians in the state, I respectfully submit this report in regards to our activities over the past year.

Crittenden County Medical Society
S. P. Schoettle, M.D., President

We feel fortunate that the Crittenden County Medical Society was not faced with the community traumas suffered in 1988. However, we endeavored to stay busy in our community as well as in our hospital. We continued to try and become more politically involved, as we feel it is our duty to do so.

Mr. Zeno came and gave us a splendid discussion on the aspect of medicine in September. Later that month, we again hosted our annual barbecue for local politicians which achieved a resounding success. We feel that we "have the ear" of our local politicians and will continue to use this avenue to achieve the goals of the State Medical Society.

We have continued our continuing medical education with our quarterly guest presentations by visiting professors.

Garland County Medical Society
Philip A. Woodward, M.D., Secretary

The Garland County Medical Society has had a quiet year. We have had no major problems or changes. Our Garland County Auxiliary has been quite active promoting a teen pregnancy program which has had a two-fold impact on our community: 1) the education of preventing unwanted pregnancies, and 2) care for teenagers who have become pregnant. We feel it is a very worth-while program and have had a very successful fund-raising golf tournament to help support this project.

Jefferson County Medical Society
David C. Jacks, M.D., President

Greetings from Jefferson County. We have had a very active year. New members joining the Jefferson County Medical Society include Drs. Bo Busby, cardiothoracic surgeon; Dennis Jacks, urologist; Mary Kathryn McGee, nephrologist; and Scott Estes, internal medicine. We have 18 family practice residents participating with the medical staff in the residency program.

The County Medical Society contributed $1,500 to the Auxiliary fund raiser to buy items for the pediatric wing of the hospital. This exciting event was called "A Golden Evening" and was a tribute to the 50-year anniversary of the Medical Auxiliary in Jefferson County.

The annual Bob Joshi Medical Society Nursing Scholarship was awarded to Miss Melissa Frye of White Hall High School. Miss Frye made a very nice speech to the group.

National Nurses Day was celebrated by a gift of coffee cups with the JRMC logo imprinted on them. These were distributed to the nurses with a kind word of appreciation from the doctors.

Med-Camps of Arkansas was supported with a $1,000

contribution from this society.

Special life memberships to the County Society was given to Drs. Calvin R. Simmons and Walter J. Wilkins. Emeritus Membership was presented to Dr. Robert L. McDonald.

Our representatives to the State Medical Society, Drs. Tom Ed Townsend, Anna Ridling, Bud Irwin, and Lee Forestiere have been generous with their time and effort. We appreciate them very much.

We are looking forward to a new year and decade and we hope to see everyone at the State Medical Society meeting this year.

Sebastian County Physicians for Better Health Care
Eugene F. Still, M.D.

The Sebastian County Physicians for Better Health Care met several times collectively and individually with most of the national and state legislators who represent our area. Legislators have been receptive to our concerns and at our urging, U. S. Representative John Paul Hammerschmidt successfully introduced legislation providing for an appeal process to be completed before denial letters are sent out to the patients by Medicare. Thanks to Rep. Hammerschmidt's cooperation, this has been a major accomplishment to the good of all physicians in the United States.

At the present time, we are continuing to meet with each and every legislator and candidate to assure ourselves that they will be aware of the concerns of physicians.

Union County Medical Society
Gary L. Bevill, M.D., Secretary

On January 18, 1989, the Union County Medical Society was the host of the annual Fifth Councilor meeting. Dr. Richard Pillsbury was elected the new president and Dr. Wayne Elliott remains as the councilor.

On May 2nd, we had a meeting with the legislators from our area. Representative Bobby Newman, Senator William Moore, and Mayor Larry Combs were in attendance. Representative Jodie Mahoney could not attend because of a legislative conflict. Mr. Lynn Zeno, of the AMS staff, who was our speaker was well received by the legislators and county members.

Later in 1989, the following new officers were elected for 1990: John Ratcliff, president; Robert Tommey, vice president; Bert Dougherty, secretary. Delegates and alternate delegates will be elected at a later date.

Medical Education Foundation For Arkansas (MEFFA)
W. Martin Eisele, M.D., President

Over the years, the report to the Society from the Medical Education Foundation For Arkansas has usually consisted of a few dry lines reciting the previous year's activities and a plea for voluntary contributions for the Foundation. This year the report will deviate from the old format to give the members of the Society a better feel for the work of the Foundation, and the appreciation by the faculty and students of the medical school for the support that the Medical Society gives them through the Foundation. The following two letters will illustrate this very well.

Letter #1, dated 12/13/89:

Dear Dr. Eisele:

On December 6, 1989, Dr. David G. Whitlock (Professor, Department of Cellular and Structural Biology, University of Colorado Health Sciences Center) visited the UAMS campus and presented a lecture entitled, "Three-Dimensional Gross Anatomy for Physicians" to the freshman medical class. As part of a lecture series the Arkansas Medical Society funded the visit in collaboration with the Department of Anatomy. I acted as coordinator for the visit and I would like to thank you for your generous support.

Dr. Whitlock's audience consisted primarily of freshman medical students, but many faculty from various departments also attended. Although the subject of the lecture was the knee joint, Dr. Whitlock's purpose was to present an exciting new approach to the imaging of body regions by use of 3-D computer reconstructions of sectioned material. He showed how this imaging system could be utilized as a gross anatomical teaching tool and how it could be invaluable as a clinical resource. His talk was stimulating and generated a great deal of student interest. In addition, Dr. Whitlock gave two presentations to groups of faculty who are interested in computer-assisted learning. The feedback from these sessions has been uniformly positive. What we learned from these sessions will undoubtedly have a significant impact on the delivery of educational material on his campus for many years to come.

You have every right to feel proud that, through the support of Dr. Whitlock's visit, your Society has enhanced the education of not only the present freshman class but of many classes of future physicians. Once again, thank you for supporting this valuable lecture series for the College of Medicine.

/s/ Patrick W. Tank, Professor
Course Director, Gross Anatomy

Letter #2, dated 11/21/89:

Dear Dr. Eisele:

I want to thank you and the Foundation for sponsoring a lecture by Dr. Richard Selzer in April. We decided to apply to other sources for additional funds to extend Dr. Selzer's visit to a full week. I can now report to you that our applications to the Donaghey Special Events Committee at UALR and to the Arkansas endowment for the Humanities have been approved, and we are planning a very full week for Dr. Selzer. I believe this unique program will be worthy of a feature article in ***The Journal of the Arkansas Medical Society***, a project I will be discussing with Stephanie Percefull in the near future.

Thank you again for the seed money which helped to make this special event possible. We will be sure to give credit to the Foundation for its assistance.

/s/ Chris Hackler
Division Head

The above two letters clearly illustrate the impact that the Medical Education Foundation For Arkansas has in its support of the medical school. It is my sincere hope that the Society will see fit to raise its annual contributions to the Foundation in support of the program as outlined above.

Arkansas Department of Health
M. Joycelyn Elders, M.D., Director

I am pleased to report on the Arkansas Department of Health's major initiatives during fiscal year 1990.

Public health faces a wide range of challenges. These challenges include immediate crisis such as AIDS; enduring problems such as tobacco use; and growing threats such as hazardous waste. These challenges call for effective, organized, and sustained efforts involving the public and private sector at the state and community levels. The partnerships we have with the AMS and its members are a critical link in meeting the challenge of public health in Arkansas.

GROWTH IN PERSONAL HEALTH SERVICES

Early and Periodic Screening, Diagnosis, and Treatment

Children eligible for Medicaid are eligible for EPSDT, Medicaid's Early and Periodic Screening, Diagnosis, and Treatment Program. The purpose of the EPSDT program is to provide a comprehensive and periodic assessment of a child's overall health, developmental and nutritional status and to provide access to needed diagnostic and treatment services. The Department performs the comprehensive assessment known as screening. The Department's commitment to this preventive health care service is evidenced by the three-fold increase in EPSDT screenings performed during the last two years. Screenings provided for non-Medicaid eligible children increased 12% last year.

Perinatal Health Services

Perinatal services in the Departments are designed to encourage early and continuous prenatal care. Potential clients receive a preliminary income screening for Medicaid eligibility. The package of expanded perinatal services also includes medical, nutritional and social assessments, case management, and prenatal education. Mothers and infants discharged within 24 hours of the infant's birth are eligible for a home visit. Although many of the Health Department's maternity patients seek private physician care after they have been determined presumptively or categorically Medicaid eligible, the number of patients in maternity clinics continues to increase statewide. Over 11,000 women received maternity services through over 50,000 clinic visits. Also, the Department established maternity clinics in five additional counties in the state fiscal year 1989, bringing the total number of clinics to 71 sites.

Immunizations

Children are immunized according to the established immunizations guidelines as they attend child health clinics and immunization clinics. In January 1989, the Arkansas Department of Health and the Department of General Education completed a joint initiative to assure that all children who attend public and private schools in Arkansas meet the requirements of the April 1989 rules and regulations pertaining to the immunization law. A comprehensive immunization random audit of 22,000 students showed that 91% of the students met requirements. The 91% level found in this audit reflects an increase of 14 percentage points over the 77% level found in 1987. The Department will continue to strictly enforce the immunization law in conjunction with the Department of Education to assure the highest levels of immunity are obtained to project Arkansas citizens.

Women, Infants, and Children

The Women, Infants, and Children Program (WIC) provides supplemental food to pregnant, postpartum and breast-feeding women, infants, and children up to five years of age. In 1988, WIC implemented a cost containment plan using open market infant formula rebates. Two formula companies agreed to an $0.87 rebate for infant formula purchased by WIC participants. This, along with other cost containment initiative, enabled the Department to increase the total WIC caseload 39%.

Sexually Transmitted Diseases

The Department provides diagnosis and referral or treatment of patients with venereal diseases as well as case management. (Interviewing and partner notification of patients and their partners.) Sexually Transmitted Diseases have continued to represent the most commonly reported communicable disease in Arkansas as well as the nation. Syphilis morbidity for the state dramatically increased during 1988. Primary and secondary syphilis reflected a 17% increase. Investigations increased 30% in state fiscal year 1989.

AIDS

HIV antibody positive reporting by name and address was required in Arkansas effective June 30, 1988. A registry of HIV positive reports is maintained by the surveillance section of the Division of AIDS/STD. Physician notification occurs for each positive report stimulating partner notification efforts and case reporting of symptomatic persons. Investigations are initiated on all HIV positive patients seen in public clinics and private HIV positive patients with physician consent. Post-test counseling and partner notification assistance are offered. A total of 4,360 follow up investigations were initiated in fiscal year 1989 on 285 positive patients and 175 contacts.

In-Home Service

The Department of Health provides three levels of in-home care virtually statewide (Home Health, Home Care, and Personal Care) and two additional levels of service (Hospice and Independence Plus) in portions of the state. Home Health provides acutely ill or recovering patients with the assistance they need to recover in their homes. Last year, Home Health served over 5,600 patients through over 180,000 visits.

Home Care Services can often prevent unnecessary re-admission to hospitals for chronically ill patients by assisting them through their chronic but unstable conditions. Home Care served over 1,100 patients last year through over 40,000 visits. Personal Care Services allowed patients an alternative to nursing homes. Last year, certified personal care aids helped 2,000 frail patients remain at home by providing 600,000 hours of services such as bathing, grooming, meal preparation, and other essentials.

The Department successfully piloted a Medicare-certified hospice in Eastern Arkansas. Hospice assists those persons who are terminally ill. Services are palliative with comfort and peace a primary goal.

NEW GRANTS AND FUNDING

Newborn Sickle Cell Screening

The United States Department of Health and Human Services awarded the Department a grant to enable screening of all Arkansas newborn infants for sickle cell disease. The funding also provides for necessary follow up. The two-year grant totals $509,881.

Disabilities Prevention

The Centers for Disease Control awarded the Department of Health and the Spinal Cord Commission a grant to prevent disabilities through the development of a comprehensive prevention program. Successful surveillance and prevention education activities will be applied to the prevention of head injuries and developmental disabilities. The two-year grant totals $714,000.

Adolescent Health

The United States Department of Health and Human Services awarded a Maternal and Child Health Improvement Project (MCHIP) demonstration grant to the Department. The grant will fund the development and implementation of a community-based model to address adolescent health needs. The town of Lakeview in Phillips County is the project's demonstration site. The project's goal is to improve the health status of Lakeview youth aged 10-19. It is the only school-based service project for adolescents currently funded by an MCHIP grant. The Department received $74,138 for the first year of the three-year grant.

Deaf Message Relay

The Communication Center's deaf message relay service operated its first full year through a contract with the DHS. The service enables persons who are hearing impaired to make telephone calls. The center, when contacted by a hearing impaired individual through his/her telecommunication device for the deaf, makes the desired telephone call and relays questions and answers between the two parties. Types of messages relayed include appointments with physicians, arrangements for child care and transportation, and transactions with banks. A special line was added to allow immediate access in the event of an emergency. A total of 23,684 messages were relayed last year. The Department's 24-hour staff of communications specialists are able to provide ideal support for this communication need.

AIDC Grants

The area management and local health unit staff works closely with local government officials and community leaders in preparing grant applications to the AIDC for construction and renovation of public health facilities. Of the nine applications submitted, five were approved totaling $1,594,284. Construction of new facilities was approved for Chicot, Jackson, Clark, St. Francis, and Yell counties.

Planning

Dr. Elders appointed three committees to assist the Department in planning current and emerging public health needs. A 24-member Long Range Planning Committee, chaired by Little Rock attorney Sheffield Nelson, represented medicine, health administration, health education, human services, and the state legislature. After seven town meetings, the committee issued a final report which included 85 recommendations. The report called for:

* Expanded health services for children and the elderly.
* Expanded health education for school-age children and the development of community-wide health promotion projects.
* Further development of statewide health data bases.
* Improved access to the Department's clinical services.
* Improved coordination of health care delivery within the state.
* Changes in third-party reimbursement to improve access to health care.
* Expanded health manpower training.

A 15-member Environmental Health Committee, chaired by Dr. Joan Cranmer of the UAMS, is working to develop environmental, occupational health and safety objectives to be accomplished by 1990, 1995, and 2000. Committee members represent private industry, medical and academic institutions, state and federal agencies, and the media. The committee's preliminary report recommended that the Department:

* Strengthen its capacity to act as Arkansas' expert and advocate in environmental and occupational health.
* Identify data needs and exchange data where possible.
* Expand laboratory services to support analytical needs.
* Examine the impact of industrial development and waste disposal on the availability of safe drinking water.
* Establish programs to address indoor air quality problems and assure occupational health and safety for workers in small businesses and on small farms.
* Hold seminars to educate the media on environmental health issues.

Dr. Lee Lee Doyle, of the UAMS, chaired the 25-member Adolescent Pregnancy Prevention Task Force. Members represented health organizations, social services, the clergy, the legislature, education, and consumers.

The report of the task force presented an analysis of the existing problem, discussed some of the causes and consequences, and suggested intervention and prevention strategies. Strategies proposed included:

* Established a commission to coordinate activities dealing with teen pregnancy.
* Develop and implement a statewide information and referral system for teens.
* Implement, as quickly and as fully as possible, educational standards grades K-12 health education.
* Identify and implement educational programs that will enhance self-esteem and encourage individual planning for long-term goals.
* Improve access to health care through service delivery alternatives, such as school-based clinics and mobile health teams.
* Establish a forum whereby the media could be encouraged to portray sexual expression in a realistic and responsible manner.
* Develop programs to reduce repeat teen pregnancies.

The findings, recommended objectives, and strategies of all three committees are serving as the basis for an ongoing, long-range public health planning process. In particular, the committees work will assist the Department as it begins leading the state in the development of year 2000 objectives for disease prevention and health promotion.

Arkansas State Medical Board
Joe Verser, M.D., Secretary

The officers and members of the Arkansas State Medical Board are W. Ray Jouett, M.D., chairman; Warren M. Douglas, M.D., vice chairman; Joe Verser, M.D., secretary/treasurer; Asa A. Crow, M.D.; Mr. John B. Currie Sr.; James L. Gardner, M.D.; John F. Guenthner, M.D.; Mr. Dewey Lantrip; Jim E. Lytle, M.D.; Alonzo D. Williams, M.D.; Rhys A. Williams, M.D.; George F. Wynne, M.D., and Wiliam H. Trice III, attorney.

On January 11, 1990, the Arkansas State Medical Board mailed the 1990 annual registration fee notices. The deadline for registration is March 1, 1990. After March 1st, a new directory will be compiled, listing all physicians and health professionals licensed by this board. Since all bids must go through the State Purchasing Director, we are not sure as yet what date the new directory will be available.

The board held a public hearing on a proposed regulation relative to post-operative care. Many individuals and allied health groups spoke for and against the regulation; however, the chairman of the board appointed a committee composed of board members to write a proposed regulation relative to post-operative care. It is anticipated another public hearing will be held once the committee makes a report.

The board investigated every case of violation of the Medical Practices Act and every complaint filed against physicians which were reported to the secretary during the year. Our office was able to successfully arbitrate a

number of these complaints. The largest number of the complaints continue to be alleged overcharging by physicians.

During 1989, the board licensed 140 physicians by examination, 139 by reciprocity, and 115 by the national board. The following is a summary of the board's proceedings:

Physicians registered in 1989:	
3,927 resident	
3,785 nonresident	
Physicians certified to other states:	145
Licenses suspended for violation of Medical Practices Act:	5
Cases pending for violation of Medical Practices Act:	9
Licenses voluntarily surrendered in lieu of a hearing:	1
Physicians DEA privileges surrendered:	1

Balance Sheets June 30, 1989 and 1988

Assets	**1989**	**1988**
Current Assets		
Cash	$249,774	$209,701
Certificates of deposit	435,749	368,868
Accrued interest receivable	7,731	4,934
Prepaid expenses	336	1,105
Total Current Assets	$693,590	$584,608
Property, Plant, and Equipment, at Cost		
Office equipment	$ 34,055	$ 33,436
Less accumulated depreciation	16,853	11,512
	17,202	21,924
	$710,792	$606,532
Liabilities and Fund Balance		
Current Liabilities		
Accounts payable	$ 55,420	$ 58,409
Deferred income	19,165	17,770
Total Current Liabilities	$ 74,585	$ 76,179
Fund Balance	$636,207	$530,353
	$710,792	$606,532

University of Arkansas College of Medicine
I. Dodd Wilson, M.D., Dean

1989 was a good year for the University of Arkansas College of Medicine. Excellent new faculty were recruited including Dr. Charles Smith, Executive Associate Dean for Clinical and Faculty Affairs; Dr. Roger Lester, Director, Division of Gastroenterology; Dr. Jon Lindemann, Director, Division of Cardiology; Dr. Bart Barlogie, Director, Division of Hematology/Oncology; Dr. Steven Teplick, Vice Chairman, Department of Radiology; and Dr. Jim Harrell, a cardiovascular surgeon. These individuals strengthened our Department of Medicine and brought new research and clinical skills to the College. We are pleased to announce a new chairman of the Department of Family and Community Medicine, Dr. Geoffrey Goldsmith. Dr. Goldsmith comes with strong credentials in occupational and community medicine. His skills will strengthen and expand our academic programs and help Arkansas deal with rural health care.

The year also saw the continued development of exciting new programs. The most important was the Arkansas Cancer Research Center (ACRC). Almost all the laboratories have already been assigned to outstanding individuals, many recruited from outside the state. The University Hospital began a bone marrow transplantation program in conjunction with the ACRC. The in vitro fertilization program which began in 1988, became very successful in 1989. Approximately $3 million was raised for our new Arkansas Center for Eye Research. Dr. John Penn joined our faculty to direct ophthalmic research in this center.

Research continues to grow in quality and quantity at UAMS. Grant funding for research in the College which was approximately $5,400,000 in 1983-84, has grown to $12,500,000 in the 1988-89 academic year. Despite the difficult federal funding situation, we expect continued growth to occur during this academic year. Areas of research strength include neuroscience, alcohol and drug abuse, musculoskeletal diseases, cancer, and geriatrics. The College is committed to continue development of these programs and to enhance research into toxicology, diseases of children, and ophthalmic problems.

We are proud of our affiliation with the Arkansas Children's Hospital and the McClellan Veterans Administration Hospital. The Arkansas Children's Hospital is the seventh largest children's hospital in the country. Its strong clinical programs are a regional resource. The McClellan Veterans Administration Hospital admits more patients and operates more beds than any other VA hospital and provides outstanding educational and research opportunities for students and faculty alike.

In education, Dr. Dick Wheeler became Associate Dean for Student Affairs, and Dr. Jay Menna became Assistant Dean for Curriculum. The College is working to strengthen the curricular content presented during the first two years. One likely change during the clinical years will be the addition of a clerkship in Family and Community Medicine. We will scrutinize the lengthy elective fourth year which is a bridge between the core medical curriculum and the first year of residency. A new promotion and

tenure policy has been implemented to reflect the importance of teaching to the institution.

Many university hospitals throughout the country are having financial difficulty including several prestigious eastern university hospitals. The number one priority of the College is to strengthen programs of the University Hospital. Other priorities for 1990 are to continue growth in research and to enhance the curriculum. The College of Medicine wishes to serve the physicians in Arkansas and appreciates your support for and input into its programs.

Report of the Task Force on Constitutional Revision

Warren Douglas, M.D., Chairman

This task force was appointed by AMS President James Weber, M.D., to carry out a recommendation in the Society's long-range plan, which was approved by the House of Delegates in April 1989. The goal was to completely review and revise the AMS Constitution and Bylaws.

The task force tried to focus on making the document comply more with modern practices and customs; making it more readable and flexible; and finally setting up mechanisms to make the AMS more accountable and responsive to the physicians of Arkansas.

In our deliberations, we were faced with, and made, very difficult decisions that, if approved, will have a major impact on the Arkansas Medical Society. Some of these provisions were approved last year by the House of Delegates. Two examples are direct membership and required attendance of officers at AMS meetings. Other major changes include:

* 90 days warning prior to a vote to increase dues
* Shorter time frame to amend constitution and bylaws
* Limits on terms of office
* Removing the offices of second and third vice president
* Allowing the AMS to charge a nominal fee to life and emeritus members
* Mandatory review of all committees

The revised document that is being presented for approval contains all of the original wording. Deletions are indicated by "strike throughs" and new language appears in italics.

I would personally like to thank the other members of the task force for their hard work and their sincere determination to improve the effectiveness and responsiveness of the Arkansas Medical Society. The members are: Amail Chudy, William Jones, James Kolb Jr., Payton Kolb, C.C. Long, and Brenda Powell.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

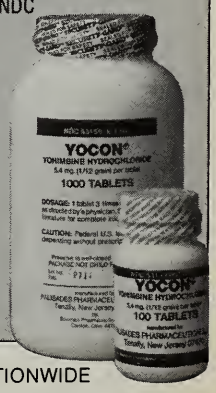
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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CONSTITUTION AND BYLAWS
of the
ARKANSAS MEDICAL SOCIETY

(Mark-Up, 1990)

CONSTITUTION

ARTICLE I. Name of Society

The name of this organization shall be the Arkansas Medical Society.

ARTICLE II. Purposes of the Society

The purposes of this Society shall be:

1. To federate and bring into one compact organization the entire medical profession of the State of Arkansas and to unite with similar societies of other states to form the American Medical Association;
2. To extend medical knowledge and advance medical science;
3. To elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws;
4. To promote friendly intercourse among physicians;
5. To guard and foster the material interests of its members and to protect them against imposition;
6. To enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life; and
7. To maintain medical ethics and to secure compliance with the art *and science* of medical practice.

ARTICLE III. Component Societies

Component societies shall consist of those societies which hold charters from this Society as provided in the Bylaws.

~~**ARTICLE IV. Composition of the Society**~~

~~Section 1. Composition~~

~~This society shall consist of members, delegates and guests.~~

~~Section 2. Members~~

~~The membership of this Society shall comprise all the members of its component societies.~~

~~Section 3. Delegates~~

~~Delegates shall be those members who are elected or seated in accordance with the Constitution and Bylaws to represent their respective component societies in the House of Delegates of this Society.~~

~~Section 4. Guests~~

~~Any distinguished physician not a resident of this State, who is a member of his own state society, may become a guest during any annual session on invitation of the officers of this Society, and shall be accorded the privilege of participating in all of the scientific work for this session.~~

ARTICLE IV. Members *(New)*

The Arkansas Medical Society is composed of individual members of its component societies and others as may be provided for in the Bylaws.

ARTICLE *V.* Sections and District Societies (Old Art. VII)

The House of Delegates may provide for a division of the ~~scientific~~ work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of ~~component societies.~~ *this Society.*

ARTICLE ~~V~~. *VI House of Delegates*

~~The House of Delegates shall be the legislative body of the Society, and shall consist of (1) delegates elected by the component societies or seated by the House of Delegates to represent component societies as provided in the Bylaws; (2) the councilors, and (3) ex-officio, the President, First Vice President, President-elect, Speaker, Vice Speaker, Secretary, Treasurer, and past presidents of the Society; provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers.~~ (Trans. to Ch. IV, Sec. 6, Bylaws)

The House of Delegates shall be the legislative and policy-making body of the Society composed of members elected by the component societies and others as provided in the Bylaws. The House of Delegates shall transact all business of the Society not otherwise provided for in this Constitution and Bylaws and shall elect the general officers except as may be provided in the Bylaws.

~~ARTICLE VI Council~~ (Moved to ARTICLE VIII)

ARTICLE *VII. General* Officers (Prev. Art. IX)

The officers of this Society shall be a president, president-elect, ~~three vice presidents,~~ *vice president,* Speaker of the House of Delegates, Vice Speaker of the House of Delegates, a secretary, a treasurer, an immediate

past president, and councilors. Their qualifications and terms of office shall be as provided in the Bylaws.

ARTICLE ~~VI.~~ *VIII* Council (Sec. 2 & 3 moved to CH. VII)

Section 1. Duties

The Council shall be the executive body of the House of Delegates and between sessions of the House shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall constitute the Finance Committee of the House of Delegates.

Section 2. Composition

The Council shall consist of the councilors, the president, ~~first~~ vice president, president-elect, secretary, treasurer, ~~and~~ immediate past president, *and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates, and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote.* ~~The Speaker and Vice Speaker of the House of Delegates and the past presidents shall be members ex-officio without vote, except that the Immediate Past President shall have a vote. There shall be two councilors from each district which has two hundred members or less. In districts where there are more than two hundred members, there shall be an additional councilor for each additional one hundred members. The councilors shall serve staggered terms of two years each. All councilors shall have equal voting privileges. A majority of the voting members shall constitute a quorum.~~

~~Section 3. Representation~~

~~Representation on the Council shall be based upon the enumeration of members in each councilor district in accordance with provisions of these Bylaws for representation in the House of Delegates.~~

Section ~~4~~ 3. Executive Committee

The Chairman of the Council, the president, the president-elect, the secretary, *the treasurer*, and the immediate past president shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have such powers and duties as provided in the Bylaws and as may be defined from time to time by resolution of the Council.

ARTICLE ~~VIII.~~ *IX* Sessions and Meetings

~~Section 1.~~

~~The Society shall hold an Annual Session, during which there shall be held daily general meetings, which shall be open to all registered members and guests.~~

~~Section 2.~~

~~The place and time for holding each Annual Session shall be decided by the Council.~~

The Society shall hold a meeting of the House of Delegates at least annually and at other times as deemed necessary or as provided in the Bylaws. The place and time for holding each meeting shall be determined by the Council.

ARTICLE X. Funds~~ and Expenses~~, *Dues and Assessments*

~~Section 1.~~

~~Funds shall be raise by an equal per capita assessment on each component society except as provided in the Bylaws. The amount of the assessment shall be fixed by the House of Delegates on four-fifths vote of the delegates present.~~

~~Section 2.~~

~~Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. Funds may be appropriated by the House of Delegates to defray the expenses of the Society for publications, and for such other purposes as will promote the welfare of the profession. All resolutions appropriating funds must be referred to the Council before action is taken thereon.~~

Funds may be raised by annual dues, or assessments, on the members of the Society except as provided in the Bylaws. The amount of dues or assessments shall be fixed by the House of Delegates on four-fifths vote of the delegates present, provided that a written notice has been sent to all dues paying members at least 90 days prior to the House of Delegates meeting. Funds may also be raised from voluntary contributions, society publications and services. All resolutions appropriating funds must be referred to the Council before action is taken thereon.

ARTICLE XI. Referendum

~~Section 1.~~

~~A general meeting of the Society~~ *The House of Delegates* may, by a two-thirds vote, ~~of the members present,~~ order a general referendum on any questions pending before ~~the House of Delegates~~ *it*, and when so ordered the House of Delegates shall submit such questions to the members of the Society, who may vote by mail or in person. If the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding upon the House of Delegates.

~~Section 2.~~

~~The House of Delegates may, by a two-thirds vote of its own members, submit any questions before it to a general referendum, as provided in the preceding section, and the result shall be binding upon the House of Delegates.~~

ARTICLE XII. The Seal

The Society shall have a common seal, with power to break, change or renew the same at pleasure, by action of the House of Delegates.

ARTICLE XIII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any ~~annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in a bulletin or journal of this Society.~~

meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.

BYLAWS

CHAPTER I. Membership

~~Section 1. Membership in Component Societies~~

~~(A) Membership in this Society shall be by membership in one of its component societies.~~

~~(B) The name of a physician on the properly certified roster of members of a component society which has paid its annual assessment shall be prima facie evidence of membership in this Society.~~

Section 1. General Requirements for Membership

A person seeking application to this Society must fulfill at least one of the following requirements: (A) Possess the degree of Doctor of Medicine or Osteopathy AND hold a license to practice medicine and surgery issued by the Arkansas State Medical Board; (B) Are Intern/Residents serving in an approved training program in this state; or (C) Are Medical Students enrolled in an approved medical school in this state.

Any person when becoming a member shall agree to abide by the Constitution and Bylaws of this Society and by any changes which from time-to-time may be made. The member further agrees to abide by the Principles of Medical Ethics of the American Medical Association.

~~Section 2. Membership Classifications~~

Section 2. Membership Categories

Categories of membership are: A. Active; B. Active Direct; C. Life; D. Emeritus; E. Affiliate; F. Associate.

~~(A) Active Membership~~

~~The active membership of this Society shall be comprised of all the active members of its component societies. Only such person is eligible for active membership in a component society as possesses the degree of Doctor of Medicine or Doctor of Osteopathy and holds an unrevoked license to practice medicine and surgery issued by the Arkansas State Medical Board. The eligibility requirements set forth in the preceding sentences are not to apply, however, to the members of the specially chartered "Student and Intern and Resident Societies."~~

(A) Active

Active members are members of component societies who are entitled to exercise the rights of membership in their component society. A person eligible for Active membership shall become a member of this Society upon certification by the secretary of the component society to the Arkansas Medical Society Executive Vice President that the person meets the requirements for membership in Chapter I, Section 1, of these Bylaws. Intern/residents and medical students shall be entitled to the same rights and privileges accorded other members except that they shall not hold office or chair committees.

(B) Active Direct

Active Direct members are those who apply for membership in this Society directly rather than through a component society. Intern/residents and medical students shall not be eligible for this category.

(1) Active Direct members are admitted to membership upon application to the Executive Vice President and after approval by the Executive Committee of the Arkansas Medical Society. When reviewing applicants for Direct membership, the Executive Committee shall establish that the applicant meets the requirements of membership as outlined in Chapter I, Section 1, of these Bylaws and may consider information pertaining to the character and ethics of the applicant. The Committee shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

(2) The Arkansas Medical Society shall immediately notify the secretary of each component society of the name and address of those applicants for Active Direct membership residing within its jurisdiction.

(3) Objections to applicants for Active Direct membership must be received by the Executive Vice President within 30 days of receipt by the component society of the notification of application. Any objections will be referred to the Executive Committee of the Arkansas Medical Society for disposition.

(4) Active Direct members shall have the right to vote, hold office, and all other privileges of membership in this Society.

~~(B)~~ *(C)* Life ~~Membership~~

A physician who has been an *Active or Active Direct* member of this Society for a period of ten years and who has continuously been a member of organized medicine and has either (1) attained age seventy or (2) practiced forty-five years shall be eligible for life membership. ~~and, upon the recommendation of his component society, shall be granted~~ such status by the House of Delegates. *Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society.* Life members shall have the right to vote, hold office, and all other privileges of membership in this Society.

~~(C)~~ *(D)* Emeritus ~~Membership~~

A physician who has been an *Active or Active Direct* member of this Society for a period of ten years and who has continuously been a member of organized medicine for less than forty-five years and who has fully retired from the practice of medicine shall be eligible for emeritus membership. ~~Such membership shall be granted by the House of Delegates upon the recommendation of the member's component society.~~ *Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society.* ~~Emeritus members shall have the right to vote, hold office, and all other privileges of membership in this Society.~~ *Emeritus members shall be entitled to all privileges of this Society except that they shall not hold office.*

~~(D)~~ *(E)* Affiliate ~~Membership~~

An *Active or Active Direct* member in good standing ~~in his component society~~ may be granted affiliate membership where one or more of the following conditions exists: physical or other disability of a character preventing the practice of medicine, a serious and prolonged illness, financial reverses, or *service in the armed forces of the United States, not as a career officer.* Affiliate membership shall be on an annual basis only and ~~a member~~ must be recommended each year for such special status by ~~his~~ *the member's* component society *or, if an Active Direct member, the Arkansas Medical Society Executive Committee* following a review and reassessment of ~~his~~ *the* particular situation. ~~An~~ *Affiliate* members shall enjoy full membership privileges except that ~~he~~ they shall not have the right to vote or hold office.

~~(E) Military Members~~

~~An active member in good standing in his component society who enters the service of the armed forces of the United States, not as a career officer, may be classified as a military member, and carried on the roll of his component society as such.~~

~~A physician entering service of the armed forces of the United States, not as a career officer, upon completion of internship or residency training shall be eligible for military membership upon the request of a component society.~~

~~Military members shall enjoy full membership privileges except that they shall not have the right to vote or hold office.~~

(F) Associate ~~Members~~

Physicians who are licensed to practice medicine and surgery in this State as well as an adjacent state and are engaged in the delivery of health services in both states may become associate members of this Society provided they are active members of the state medical association in the adjoining state. Associate members may vote as provided in this Constitution and Bylaws and may serve on all committees, but shall not hold office.

~~(G) Intern and Resident Members~~

~~Physicians licensed to practice medicine and surgery in this State who are engaged in filling intern or residency appointments in approved hospitals shall be eligible for membership in this Society. Such membership shall end with termination of this status. Such members shall enjoy the rights and privileges accorded active members except that they shall not hold office or chair committees.~~

~~(H) Student Members~~

~~Students enrolled in an approved medical school shall be eligible for student membership in this Society. Student members shall enjoy the rights and privileges accorded active members except that they shall not hold office or chair committees.~~

Section 3. Dues Exemption

(A) Life, emeritus, affiliate, ~~military~~, ~~intern and~~ intern/resident, and student members shall be exempt from the payment of dues and assessments.

(B) Associate members shall pay one-half of all dues and assessments.

(C) New active members of the Society entering practice in Arkansas shall be exempt from dues from the date of entry into practice until the next regular dues period. The following year, the dues assessment shall be at one-half the total amount. Thereafter, full dues are payable.

(D) The House of Delegates upon recommendation from the Council, may assess a nominal annual fee on Life and Emeritus members to cover administrative and overhead costs associated with providing Society publications and services.

Section 4. Delinquency

Members are considered delinquent if their dues and assessments are not received by this Society by March 1, of each year, or by such other date as may be prescribed by the House of Delegates. Delinquent members shall not be entitled to any rights or benefits of this Society, nor shall they take part in any of its proceedings until such delinquency has been resolved.

~~Section 4. Suspension or Expulsion~~

~~Any person who is under sentence of suspension or expulsion from a component society or whose name as been dropped from its roll of members, shall not be entitled to any of the rights or benefits of this Society, nor~~

shall he be permitted to take part in any of its proceedings until he has been relieved of such disability.

Section 5. Suspension or Termination of Membership

A) Any member shall have their membership suspended or terminated for failure to pay their annual dues and assessments or upon official notification from a component society that a member is not in good standing, subject to the member's right of appeal as provided in Section 6 of this Chapter.

(B) The Executive Committee, after due notice and hearing, may suspend or terminate a person's membership in the Arkansas Medical Society for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct, subject to the member's right of appeal as provided in Section 6 of this Chapter.

(C) Membership in the Arkansas Medical Society shall automatically be terminated if a member ceases to meet the requirements for membership as specified in Section 1 of this Chapter. This provision shall not apply to Life or Emeritus members who have fully retired from the practice of medicine.

Section 5. Meeting Registration

Each member, each member chosen as a delegate, and each guest in attendance at an annual session of the Society shall register in such manner as may be provided by the Executive Vice President, giving his name, address, and the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that session. No member shall take part in any of the proceedings of an annual session until he has complied with the provisions of this section.

Section 6. Appeals

(A) Any member who may feel aggrieved by the action of this Society or of the member's component society in denying membership, or in suspension or termination, shall have the right to appeal to the Council.

(B) Notice of Appeal shall be filed with the Council within thirty (30) days of the date of the action on which the appeal is taken, and the appeal shall be perfected within ninety (90) days thereof. The decision of the Council shall be final.

(C) The Council chairman shall have the power to appoint special committees from among the members of the Council to hear appeals; provided no member from the same councilor district as the appellant shall serve on said committee.

(D) The Council shall establish rules and procedures to be followed in hearing appeals and shall furnish these to all parties involved in the appeal upon receipt of the Notice of Appeal.

Section 6. Continuing Medical Education

Continued membership in the Society is dependent upon compliance with continuing medical education requirements as specified below:

(A) Classification of Members Affected

All members of the Society will comply with this charge, except those retired from practice, those still engaged in their formal medical or specialty education, non-resident members and those in full-time administrative positions. Those members unable to fulfill requirements because of impaired health or extenuating circumstances may be exempt on a temporary basis by the Committee on Continuing Medical Education.

(B) Central Authority

The Committee on Continuing Medical Education will be charged with the determination of the requirements for maintaining membership in the Society. Their initial determination as well as any changes recommended must be submitted to the House of Delegates for approval. Alterations in the number of hours of continuing medical education required may be made at any regular meeting of the Society by the House of Delegates. The Council will serve as an arbitration committee if a decision of the Committee on Continuing Medical Education is questioned.

(C) Acceptable Alternate Plans

Alternate plans of acceptable requirements which would be considered equal or exceeding the requirements established by the Committee on Continuing Medical Education and the House of Delegates would include:

(1) Compliance with the requirements for the Physician's Recognition Award of the American Medical Association;

(2) Compliance with the continuing education requirements of the American Academy of Family Physicians;

(3) Documentation of recertification by any specialty board provided the physician limits his practice to the definition of the specialty;

(4) The continuing medical education requirements of specialty societies other than the American Academy of Family Physicians should such become established. Such programs would be subject to review by the Committee on Continuing Medical Education prior to their acceptance.

(D) Three-year Continuum

Each member subject to continuing medical education requirements shall have three years to complete the required hours. The three-year continuum begins January 1 of the initial year.

~~CHAPTER II. Annual and Special Sessions of the Society~~ (Moved to Chapter III)

CHAPTER II. **Component Societies** (Formerly Chapter IX)

Section 1. Charters for Component Societies

(A) All component societies now in affiliation with this Society or those which may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application and submission of their Constitution and Bylaws, receive a charter from and become a component part of this Society.

(B) As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.

(C) Charters shall be issued only on approval of the Council, and shall be signed by the President and Secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Section 2. Component Organization

Only one component medical society shall be chartered in any county, except in the county where the University of Arkansas College of Medicine is located. In that county there may be, in addition to the regular county medical society, one component society for interns and residents and one component society for medical students. Where more than one component society exists in any other county, friendly overtures and concessions shall be made, with the aid of the councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 3. Membership Qualifications

Each component society shall ~~be the~~ judge ~~of~~ the qualifications of its own members, but as such societies are ~~the only portals of this Society and to the American Medical Association,~~ *chartered components of the Arkansas Medical Society,* every ~~reputable~~ person who possesses the qualifications for membership required by Chapter I, Section ~~2~~ *1* of these Bylaws~~, and who does not practice or claim to practice nor lend support to any exclusive system of medicine,~~ shall be eligible for membership. ~~No physician or surgeon who solicits patients or business for himself, or for an association or other organization of which he is a member, or by which he is employed, or in which he is interested, shall be eligible for membership in this Society, and no physician who works for, is employed by, or is interested in, any association or organization which solicits patients, members or physicians, shall be eligible for membership in this Society. Any member of the Society who shall hereafter violate any of the provisions hereof shall be expelled from the Society. Before a charter is issued to any county society, full and ample notice shall be given to every such physician in the county to become a member.~~

~~Section 4. Appeal to the Council~~

~~Any physician who may feel aggrieved by the any action of the Society of his county in refusing him membership or in censoring, suspending, or expelling him, shall have the right to appeal to the Council, and its decision shall be final except that a county component society shall at all times, be permitted to appeal or refer questions involving its membership to the House of Delegates of the Arkansas Medical Society for final determination. That the Council may be aided in rendering just decisions, it is necessary that the Bylaws of each component society provide in detail the procedure to be followed in preferring charges and trying any member accused of and tried for any kind of unprofessional conduct.~~

~~In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts; but in case of every appeal, both as a Board and as individual councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.~~

Section ~~5~~. *4* Transfers

~~When a~~ *Members* in good standing in a component society *who* move to another county in this State ~~he~~ shall be given a written certificate of these facts by the secretary of ~~his~~ *the component* society, without cost, for transmission to the secretary of the society in the county to which ~~he~~ *they* move. Pending ~~his~~ *their* acceptance or rejection by the society in the county to which ~~he~~ they move~~s~~, such member shall be considered to be in good standing in the county society from which ~~he was~~ *they were* certified and in the ~~state~~ *Arkansas Medical* Society to the end of the period for which ~~his~~ *their* dues have been paid.

Section ~~6~~. *5* County Jurisdiction

~~A~~ *P*hysician*s* living near a county line may hold ~~his~~ *their* membership in that county society most convenient for ~~him~~ *them* to attend, on permission of the component society in whose jurisdiction ~~he~~ *they* reside.

Section ~~7~~. *6* Efforts to Increase Membership

Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section ~~8~~. *7* Representation in the House of Delegates

~~(A) Each regular county medical society shall be entitled to one delegate to the House of Delegates~~

~~of this Society for each twenty-five members or major fraction thereof, provided that the society has complied with other provisions of these Bylaws, and provided that each component society shall be entitled to one delegate.~~

~~(B) The component society of interns and residents shall be entitled to one delegate to the House of Delegates.~~

~~(C) The component society of medical students shall be entitled to one delegate to the House of Delegates.~~

~~(D)~~ At some meeting in advance of the Annual Session of this Society, each component society shall elect a delegate or delegates to represent it in the House of Delegates as provided in *Chapter IV, Section 7 of* these Bylaws and the secretary of the component society shall send a list of such delegates to the Executive Vice President of this Society at least ten days before the Annual Session.

Section ~~9~~. *8* Responsibilities of secretary

The secretary of each component society shall *endeavor to* keep a roster of its members, and of the non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state and such other information as may be deemed necessary. In keeping such roster, the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making ~~his~~ *the* annual report ~~he~~ shall endeavor to account for every physician who has lived in the county during the year.

~~Section 10. Assessment~~

~~The Secretary of each component society shall forward its assessment, together with its roster of officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Society on January 1st, and not later than March 1st of each year.~~

Section 9. Annual Report

The secretary of each component society shall forward its Annual Report to the offices of this Society no later than March 1 of each year. Such report shall include but not be limited to:

A. Names of officers and their terms
B. Names of delegates
C. Names of physicians who have been dropped from membership
D. Names of deceased physicians
E. Names of members requesting change in membership category
F. Any dues and assessments collected by the component society in behalf of the Arkansas Medical Society and/or American Medical Association. Such monies shall be accompanied by a listing of the name, address, and amount remitted for each member.

~~Section 11. Failure to Pay Assessment~~

~~Any county society which fails to pay its assessment, or make the report required, on or before March 1st, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.~~

Section 10. Failure to Submit Annual Report

Any component society which fails to remit any dues and assessments collected in behalf of the Arkansas Medical Society and/or American Medical Association or who fails to submit the Annual Report, as defined in Chapter II, Section 9, on or before March 1 of each year, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of this Society or of the House of Delegates until such requirements have been met.

CHAPTER III. **Annual And Special Sessions Of The Society**

Section 1.

The Society shall hold an Annual Session *of the House of Delegates* at such place as has been fixed by the Council. ~~at the annual session two years in advance.~~

Section 2.

Special meetings of ~~either the Society or~~ the House of Delegates shall be called by the President on petition of the Council, twenty delegates, or fifty members.

~~**CHAPTER III. General Meetings**~~

~~Section 1.~~

~~All registered members may attend and participate in the proceedings and discussions of the general meetings and of the Section. The general meetings shall be presided over by the President or by one of the Vice Presidents, and before them shall be heard the address of the President and the orations, and such scientific papers and discussions as may be arranged for in the program.~~

~~Section 2.~~

~~The general meetings may recommend to the House of Delegates the appointments of committees or commissions for scientific investigations of special interest and importance to the profession and public.~~

CHAPTER IV. House Of Delegates

Section 1.

The House of Delegates shall meet on the first day of the Annual Session. It may ~~adjourn~~ *recess* from time to time as may be necessary to complete its business; provided that its hours shall not conflict with the general meetings.

Section 2.

The order of business shall be arranged as a separate section of the Annual Session program.

Section 3.

The House of Delegates shall establish its own rules of procedure.

Section 4. Items of Business

(A) All reports and resolutions received by the

Executive Vice President sixty days prior to the annual meeting of the House of Delegates of this Society shall be printed in the Journal of the Arkansas Medical Society in the month preceding the meeting.

(B) All reports, resolutions, and other items of business received by the Executive Vice President twenty days prior to a meeting of the House of Delegates shall be included in the meeting agenda.

(C) Any item of business not submitted to the Executive Vice President twenty days prior to the meeting of the House of Delegates must have a two-thirds consent of attending delegates for introduction at such session.

Section 5. Reference Committees

(A) The Speaker of the House of Delegates shall appoint an appropriate number of reference committees from the membership. ~~of the House of Delegates.~~ The Chairman shall be appointed by the Speaker. The reference committees shall serve only during the convention for which they are appointed.

(B) All reports of committees, reports of officers, and resolutions submitted for consideration of the House of Delegates shall be referred to a reference committee, unless otherwise provided in these Bylaws, or unless otherwise ordered by a two-thirds vote of the House of Delegates.

(C) The reference committee shall hold an open hearing at which any member of the Society may speak on proposals before the committee.

(D) The reference committee shall recommend to the House of Delegates an appropriate course of action on each proposal referred to the committee.

Section 6. Composition

The House of Delegates shall consist of:

(A) Delegates elected by component societies in accordance with Section 7 of this chapter, or as provided in Section 10 of this chapter

(B) The Councilors

(C) ~~Ex-officio, the~~ *The president, vice president, president-elect, speaker, vice speaker, secretary, treasurer, and past presidents of the Society;* ~~provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers.~~

Section ~~6.~~ 7 Representation of Component Societies

Representation for the House of Delegates shall be based upon the number of active, *active direct*, ~~members,~~ life ~~members~~, emeritus ~~members~~, and associate members as of December 31 of the year preceding the annual meeting. *Medical student and intern/resident members shall not be included in the enumeration of active and active direct members for purposes of representation.*

(A) Each regular county society shall be entitled to send to the House of Delegates each year one delegate for every twenty-five Arkansas Medical Society members, as specified in ~~(A)(1)~~ *this section*, and one for each major fraction thereof, provided that its annual report ~~and assessment~~ are in the hands of the Executive Vice President by March 1st of each year. Each county society~~, however, regardless of its number of members,~~ which has complied with this section, shall be entitled to *at least* one delegate.

(B) The component society composed of ~~intern and~~ intern/resident members shall be entitled to one delegate to the House of Delegates.

(C) The component society composed of *medical* student members shall be entitled to one delegate to the House of Delegates.

Section ~~7~~ 8.

A majority of the delegates registered shall constitute a quorum.

~~Section 8.~~

~~The House of Delegates shall, through its officers, Council and otherwise, give diligent attention to and foster the scientific work and spirit of the Society and shall constantly study and strive to make each Annual Session a stepping stone to future ones of higher interest.~~

~~Section 9.~~

~~It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein it is dependent on the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.~~

~~Section 10.~~

~~It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of the same locality, and shall continue these efforts until every physician in every county of the State who is reputable and eligible has been brought under Medical Society influence.~~

~~Section 11.~~

~~It shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.~~

~~Section 12.~~

~~It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body.~~

~~Section 13.~~

~~It shall divide the State into councilor districts, specifying what counties each district shall include and,~~

~~when the best interest of the Society and profession will be promoted thereby, organize in each a district medical society, and all members of component societies the Arkansas Medical Society shall be members in such district society.~~

~~Section 14.~~

~~It shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.~~

~~Section 15.~~

~~It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.~~

Section 9. The House of Delegates shall:

(A) elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body,

(B) divide the State into councilor districts, specifying what counties each district shall include and, when the best interest of the Society and profession will be promoted thereby, organize in each a district medical society, and all members of ~~component societies~~ the Arkansas Medical Society shall be members in such district society,

(C) have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports,

(D) approve all memorials and resolutions issued in the name of the Society before they shall become effective, and

(E) it shall transact all business of this Society not otherwise provided for herein.

Section ~~16~~ *10.*

In case of vacancy in the office of delegate, the House of Delegates shall have the authority to seat any member of that county society in attendance at said meeting as delegate, with full right to perform all the duties of that office.

CHAPTER V. Election of Officers

Section 1. Nominating Committee

The Nominating Committee shall consist of ten members of the House of Delegates, one from each councilor district. Each member of the committee shall serve for a term of two years, the terms being staggered so that odd and even numbered councilor district representatives shall be replaced on alternate years. ~~In the first year following adoption of this amendment, the odd numbered councilor district appointees shall serve for one year, the even numbered councilor district appointees shall serve for two years.~~ The names of the delegates appointed to the nominating committee shall be submitted by the senior councilors in the districts to the Executive Vice President no later than thirty days prior to the annual meeting. Following the first meeting of the House of Delegates at the Annual Session, the Nominating Committee shall meet and organize by selecting a chairman and a secretary. It shall be the duty of this committee to consult with members of the Society and to hold one or more meetings at which time the best interest of the Society and of the profession of the State for the ensuing year shall be carefully considered. The committee shall report the result of its deliberations to the headquarters office no later than February 1 in the shape of a ticket containing the ~~names of two or more members for the office of president-elect and~~ *name* of one member for each of the ~~other~~ offices to be filled at the Annual Session. ~~No two candidates for president-elect shall be named from the same county.~~

Section 2.

Nothing in this Chapter shall be construed to prevent additional nominations being made by members of the House of Delegates.

Section 3.

No member shall be ~~eligible~~ *elected* to any office of this Society who is not in attendance at the meeting at which the election is held. Exceptions may be made by the House of Delegates if the nominee is unable to be present because of circumstances beyond his control.

Section 4.

The election of officers shall be the first order of business of the House of Delegates on the last day of the Annual Session.

Section 5. Election by Ballot

All elections shall be by *written* ballot, except where there is only one candidate, when election may be made by acclamation, and a majority of the votes cast shall be necessary to elect.

Section 6. *Terms of Office*

~~Councilors shall be elected to serve a two-year term; all other terms of office are for one year. All officers shall serve until their successors are installed.~~

(A) Councilors shall be elected to serve a two-year term; provided no councilor shall serve more than three consecutive terms.

(B) Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the Bylaws of that organization; provided no member shall serve as Delegate more than eight consecutive years.

(C) All other terms of office shall be for one year; provided no member shall serve more than six consecutive years in the same office.

(D) Members who have served in an office for the maximum number of years or terms are eligible for re-election to that same office after one year.

(E) All officers shall serve until their successors are installed.

Section 7.

On the expiration of ~~his~~ *the* term as president-elect, that person shall automatically succeed to the presidency and shall serve as president for the ensuing year.

Section 8. Vacancy in Presidency

In the event of the death or removal of the President, the President-elect shall succeed to the presidency to serve the remainder of that year and the ensuing year.

Section 9. Vacancy in Office of President-elect

In the event of the death or removal of the President-elect or ~~his~~ *the* inability to serve, the ~~House of Delegates shall meet within thirty days in a special session or otherwise, called by the President, to nominate and elect a president-elect, provided that such death, removal or inability to serve shall occur not less than sixty days prior to the Annual Session, in which event the election shall be at the forthcoming Annual Session.~~ *Vice President shall succeed to the position until the next Annual Session at which time a special election for the office of President shall be held.*

Section 10. Councilor Vacancy

In the event of the death or resignation of a district councilor, the Council shall appoint a member of the district to fill the unexpired term. The remaining councilors for the district shall confer with members in the district and make nominations for the vacancy to the Council.

Section 11. Vacancy in Office of Secretary or Treasurer

In the event of a vacancy in the office of the Secretary or of the Treasurer, the Council shall fill the vacancy until the next annual election.

CHAPTER VI. Duties of Officers

Section 1. President

The President shall preside at all meetings of the Society and shall appoint all committees not otherwise provided for. ~~He~~ *The President* shall deliver an annual address at such time as may be arranged, and shall perform such duties as custom and parliamentary usage may require. ~~He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit by appointment the various sections of the State and assist the councilors in building up the county societies, and in making their work more practical and useful.~~

Section 2. President-elect

The President-elect shall be a member of the Council and the House of Delegates. It shall be ~~his~~ *the President-elect's* duty to assist the President in visiting the component and district societies, and to ~~familiarize himself~~ *become familiar* with, and prepare ~~himself~~ for, the performance of ~~his~~ *the* duties ~~when he shall have succeeded to the presidency of the Society.~~ *of the office of President. In the event of the President's temporary inability to serve, the President-elect shall serve until such time as the President is able to return.*

Section 3. ~~Vice Presidents~~ *Vice President*

~~(A)~~ The Vice President shall assist the President in the discharge of ~~his~~ *the President's* duties. ~~In the event of the President's temporary inability to serve, the First Vice President shall serve in his stead.~~

~~(B)~~ The Vice Presidents may be assigned by the President ~~of the Society~~ as *an* ex-officio members of certain committees of the Society. The Vice President's responsibilities will be to stimulate, to guide, to maintain liaison, and to otherwise assist the assigned committees and their respective chairmen in the performance of their activities. In no instance will the Vice President usurp or supplant the committee ~~chairman~~ *chairmen* in ~~his~~ *their* responsibilities. The Vice President shall not have a vote in the affairs of the committees *assigned* ~~to which he is assigned~~ under provisions of this section.

Section 4. Treasurer

The Treasurer shall give bond in the sum as directed by the Council, ~~He~~ *and* shall demand and receive all funds due the Society, together with bequests and donations. ~~He~~ *The Treasurer* shall pay money out of the treasury only on a written order of the Executive Vice President; ~~he~~ *and* shall subject ~~his~~ *the Society's* accounts to such examinations as the House of Delegates may order. ~~and he~~ *The Treasurer* shall annually render an ~~account of his doings and of the state of the funds in his hands.~~ *accounting of the state of the Society's funds.*

Section 5. Secretary

The Secretary, in case of vacancy in the office of the executive vice president, shall assume the duties of that office pending the filling of the vacancy, and shall perform such other duties as are imposed by the Constitution and Bylaws. ~~He~~ *The Secretary* shall be the scientific and professional advisor of the Executive Vice President. ~~and shall assist the Executive Vice President concerning all matters without the jurisdiction of one not holding the degree of Doctor of Medicine. The Secretary, as defined by the Constitution, shall be known as the Constitutional Secretary.~~

Section 6. The Speaker of the House

The Speaker of the House of Delegates shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

Section 7. The Vice Speaker

The Vice Speaker shall officiate for the Speaker in the latter's absence or ~~at his~~ *by* request. In case of death, resignation, or removal of the Speaker, the Vice Speaker shall officiate during the unexpired term.

Section 8. Councilors

~~Each~~ *Every* councilor shall be organizer, peacemaker, and censor for ~~his~~ *their* district. The one in each district with the longest tenure shall be considered the

senior councilor. It is recommended that the councilors in each district call a meeting of the members in the district at least once each year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for informing, improving, and increasing the knowledge and zeal of the component societies and their members.

~~The councilors shall jointly prepare and submit to the Council prior to the Annual Session a written report of their work and of the condition of the profession within their district.~~

~~The necessary traveling expenses incurred by each councilor in the line of the duties herein imposed may be allowed on submission of a properly itemized statement.~~

Section 9. Chairman of the Council

The Chairman of the Council shall (1) preside at all meetings of the Council, (2) serve as Chairman of the Executive Committee of the Council, and (3) appoint the Council committees.

CHAPTER VII. Council

Section 1. Power and Duties

(A) The Council shall be the executive body of the House of Delegates and between Annual Sessions exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members ~~of component societies,~~ on which an appeal is taken~~. from the decision of an individual councilor.~~ The Council shall elect a chairman following election of the Council members by the House of Delegates.

(B) The Council shall be responsible for the conduct of all the business affairs of the Society. It shall employ a chief executive officer who shall be known as the Executive Vice President.

(a) The Executive Vice President shall be responsible for implementation of policies of the Society and conducting affairs of the Society under the direction of the Council and its Executive Committee, the House of Delegates and the President. The Executive Vice President shall be the directing manager of the Society's headquarters office and the Journal office, and shall supervise the work of all salaried employees in the Society's offices. ~~He~~ *The Executive Vice President* shall discharge the administrative functions of the Society not within the duties of other officers or of committees to perform ~~He~~ *and* shall assist, at their request, all officers and committees. ~~and~~ *The Executive Vice President* shall keep ~~himself~~ informed in regard to nonprofessional matters affecting the medical profession, for the purpose of ~~keeping himself~~ *remaining* qualified to perform the services herein mentioned. The amount of ~~his~~ salary shall be fixed by the Council and ~~he~~ *the Executive Vice President* shall give bond as directed by the Council.

Section 2. Composition

The Council shall consist of the councilors, the president, vice president, president-elect, secretary, treasurer, immediate past president, and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote.

Section 3. Representation

Representation on the Council shall be based upon the enumeration of members in each councilor district in accordance with the provision for representation in the House of Delegates as defined in Chapter IV, Section 7 of these Bylaws.

Section ~~2~~ *4*. Organizing Component Societies

The Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section ~~3~~ *5*. Publications and Records

The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memories of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Society. It shall annually audit the accounts of the Treasurer and Secretary and other agents of this Society and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

Section ~~4~~ *6*. Meetings

The Council shall meet on the first day of the Annual Session and daily during the session and at such other times as necessary, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Society to organize and outline the work for the ensuing year. Between Annual Sessions, the Council shall ~~be expected to~~ meet at least

~~bimonthly~~ *quarterly.*

Section ~~5~~ *7.* Reporting

The Council shall, through its chairman, make an annual written report to the House of Delegates.

Section ~~6~~ *8.* Bonds

The Council shall have authority to accept or reject all bonds, *commitments and contracts.*

Section ~~7~~ *9.* Committees

(A) Executive Committee

The Chairman of the Council, the President, the President-elect, the Secretary, *the Treasurer,* and the Immediate Past President shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have the power and authority to act for the Council between meetings of that body; all actions of the Executive Committee shall require approval or ratification of the Council. The Executive Committee shall consider matters referred to it by officers of the Society and shall report its findings or recommendations to the Council. *The Executive Committee shall have jurisdiction in all matters pertaining to (1) Active Direct membership and (2) discipline of members, subject to the member's right of appeal as provided in Chapter 1, Section 6 of these Bylaws.*

B) Budget Committee

The Budget Committee shall consist of (a) four members appointed by the Chairman of the Council from among the councilors, and (b) the Arkansas Medical Society treasurer. The four council members shall be appointed to four-year terms, staggered so that one member is replaced each year. The terms shall begin on January 1 and end on December 31 of the appropriate years. The member with the most seniority shall serve as chairman. The Budget Committee shall present to the Council, before the first of each year, an annual budget consisting of anticipated revenue and expenses for the ensuing year as well as a report of the Society's committed and non-committed reserves. Any significant request for funds not included in the annual budget should be reviewed by the Budget Committee before they are committed. The Budget Committee shall provide for an annual independent financial audit and work to maintain the most prudent use of Society assets.

~~(B)~~ *(C)* Council Committees

The Chairman shall, with concurrence of the Council, appoint such committees as are necessary to carry out the duties assigned to the Council by the Bylaws and House of Delegates. ~~At the discretion of the Council, the committees shall be of three types: (1) standing committees with unlimited membership tenure; (2) standing committees with staggered membership terms; and (3) ad hoc committees as may be warranted for specific purposes.~~

Section ~~8.~~ *10.* Appointments to Fill Vacancies

The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates.

~~**CHAPTER VIII. Committees**~~

~~Section 1.~~

~~(A) The standing committees of this Society shall be as follows:~~

1. Committee on Cancer Control
2. ~~Committee of Medical Legislation/Subcommittee on National Legislation~~
3. ~~Committee on Public Health/Subcommittees on Rural Health, Maternal and Child Welfare, Tuberculosis, Heart Association, Liaison with Nursing Profession, etc.~~
4. ~~Committee on Continuing Medical Education~~
5. ~~Committee on Hospitals/Hospital Liaison and Arkansas Hospital Association~~
6. ~~Committee on Public Relations/Speakers' Bureau, Liaison with Auxiliary, Liaison with Medical Assistants, Civilian Defense, etc.~~
7. ~~Committee on Annual Session~~
8. ~~Committee on Insurance~~
9. ~~Committee on Medicine and Religion~~
10. ~~Committee on Aging~~
11. ~~Committee on Mental Health~~

~~(B) Additional committees shall be considered subcommittees of the appropriate standing committee and one member of the standing committee shall be a member of the subcommittee.~~

~~(C) Unless otherwise provided, these committees shall be appointed by the President for three-year staggered terms. The committee shall consist of not less than six members each, with each president appointing two members for a three-year period. Any vacancies through death, removal or resignation may be filled by the President at the time the vacancy occurs and for the unexpired term of the vacancy. The President and the Secretary shall be ex-officio members of all committees.~~

~~Section 2. The Duties of the Committees shall be as follows:~~

~~Committee on Cancer Control. Shall represent the Society in all activities concerned with cancer in the State. Shall directly supervise the activities of the Cancer Control Committee of the Arkansas Medical Society Auxiliary. Shall cooperate with all agencies within the State of Arkansas dedicated to the problem of cancer.~~

Committee on Medical Legislation. Shall represent the Society in all legislative practice. It shall keep in touch with professional and public opinion and maintain active relations with the Department of Public Affairs of the American Medical Association. It shall, at all times, endeavor to shape and guide legislation with a view to securing the best results for the whole people. It shall strive to organize professional influence so as to promote the general good of the community in local, state, and national affairs and elections. During sessions of the General Assembly, it shall keep itself informed as to the bills that are introduced, and shall inform the members of the Society through its journal or special bulletins to the end that legislation inimical to the medical profession and the public shall be defeated, and legislation fostering the interest of the public health and medical practice shall be enacted into law.

Committee on Public Health. Shall represent the Society in those affairs having for their objective the improvement in public and personal health, the prevention of epidemics, and the instruction of the people. It shall maintain close relations with the Board of Health, the State Health Officer, and the various health officials, assisting in the adoption of public health programs, the enforcement of sanitary laws, and to exercise the leadership in the health problems of school children through a subcommittee on physical fitness and school health. As occasion demands, or when thought advisable, it shall supervise the preparation of articles of timely interest for publication in the newspapers or for broadcasting over the radio for the instruction of the public.

The Committee on Continuing Medical Education shall be responsible for consideration of all questions pertaining to medical education. It shall maintain close relations with the officials and faculty of the University of Arkansas School of Medicine, and Arkansas Academy of Family Physicians, and other groups interested in maintaining and improving medical education in our State institutions. It shall foster continuous efforts to increase excellence in the system of post-graduate education to serve the cause of medicine and to assure the public of continuing improvement in the postgraduate training of physicians in practice.

The committee shall determine continuing medical education requirements for maintaining membership in the Society, as provided in these Bylaws, and shall establish methods of reporting in compliance with the continuing medical education requirements.

The Committee on Continuing Medical Education shall consist of seven members appointed by the President as follows: The dean or a representative of the University of Arkansas College of Medicine; one representative of the Arkansas Academy of Family Physicians from three nominees by that group; one family physician member of the Society selected by the President; one surgeon selected from three nominations from the Arkansas Chapter of the American College of Surgeons; one internist selected from three nominations from the Arkansas Chapter of the American College of Physicians and two other members of the Society, not in the specialty categories listed above, selected by the President. The committee chairman shall be named by the President.

Committee on Hospitals. The Committee on Hospitals shall have referred to it all questions pertaining to hospitals and their operations; hospitalization of patients and hospital-physician relationships.

Committee on Public Relations. The Committee shall have referred to it all questions wherein the medical profession as represented by the Society is called upon for advice, for participation in private or public affairs and projects not coming within the duties outlined for the other committees. It shall be the publicity committee of the Society and shall have charge of all publicity issued in the name of the Society. The subcommittee on professional relations shall function under this committee.

Committee on Annual Session. The committee shall determine the character and scope of the scientific program for each Annual Session. It shall prepare a scientific program for each Annual Session. It shall solicit and collect material from institutions and individual physicians of the State that is of scientific interest. This it shall arrange and exhibit at each Annual Session. It should particularly strive to obtain material that will more fully illustrate the papers presented in the general meeting of the Society.

The committee shall provide suitable accommodations for meetings of the Society and the House of Delegates, the scientific exhibits, the committees, and shall have general charge of all arrangements. Its chairman shall report an outline of the arrangements to the Executive Vice President for publication in the program and shall make additional announcements during the session as occasion may require.

Committee on Insurance. The Committee on Insurance shall deal with all matters pertaining to insurance, including liaison with Blue Cross-Blue Shield.

The Committee on Medicine and Religion shall work to create and enhance communication between physician and clergyman which will lead to the most effective care and treatment of the patient in which both are interested. It shall study the areas in which there is or may be continuing correlation involving medicine and religion.

The Committee on Aging shall study the problems of the aged and the aging. It shall provide leadership and initiative in meeting the health and medical care requirements of older persons. It shall foster the development of effective methods of achieving the best possible social and spiritual atmosphere for the elderly.

The Committee on Mental Health shall study the problems of the mentally ill. It shall foster development of programs to improve the care and treatment of mental patients and mental retardates.

CHAPTER VIII. Committees

Section 1. Committees may be appointed by the president, chairman of the Council, or as may be so ordered by the House of Delegates to carry out the goals and responsibilities of this Society.

Section 2. Unless otherwise provided, all committees will be of two types: (1) Standing committees with staggered membership terms; and (2) Ad Hoc committees and Task Forces for specific purposes with limited duration.

Section 3. All committees shall have a written mission-statement that includes to whom the committee reports, the goal or purpose of the committee, and when applicable, the perceived or required time-frame for completion of the committee's work.

Section 4. All committees except those required by the Constitution and Bylaws shall be evaluated periodically, but not less than once every three years, to identify and abolish or restructure committees that are non-functional or whose purpose or mission has significantly changed or ended. It shall be the responsibility of the Executive Committee to conduct such evaluation and make recommendations to the appropriate body.

Section 5. Unless otherwise provided, standing committees shall consist of at least six members with each member appointed to a three-year term; provided no member shall serve more than two consecutive terms.

~~CHAPTER IX. Component Societies~~ **(Changed to Chapter II)**

CHAPTER IX. Required Attendance By Elected And Appointed Members

Any member, appointed or elected, to any position within this Society who is absent from three consecutive meetings, or who annually misses fifty percent of the meetings of the body to which they serve, shall be presumed to have resigned that position.

~~CHAPTER X. Miscellaneous~~

~~Section 1.~~

~~No address or paper before this Society, except those of the President and orators, shall occupy more than thirty minutes in its delivery and no member shall speak longer than five minutes nor more than once on any subject, except by unanimous consent.~~

~~Section 2.~~

~~All papers read before the Society or any of the sections shall become its property. Each paper shall be deposited with the Secretary when read.~~

CHAPTER ~~XI~~ *X*. Parliamentary Procedures

The deliberations of this Society shall be governed by parliamentary usage as contained in *Sturgis Rules of Parliamentary Procedure*, when not in conflict with this Constitution and Bylaws.

CHAPTER ~~XII~~ *XI*. Medical Ethics

The Principles of Medical Ethics promulgated by the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

CHAPTER ~~XIII~~ *XII*. Amendments

The House of Delegates may amend any chapter of these Bylaws by a two-thirds vote of the delegates present at any ~~Annual Session, provided that each amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been published twice during the year in a bulletin or journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.~~ *meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.*

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(501) 636-0200.

AIDS IN ARKANSAS 1990
January 1 - December 31, 1990

Total number of cases reported	26
Number of deaths	7

CASES BY SEX

Male	25
Female	1

CASES BY RACE

White	23
Black	3
Other	0

CASES BY RISK GROUP

Homosexual/Bisexual	21
Homosexual & IV Drug User	4
IV Drug User	0
Hemophiliac	1
Transfusion	0
Heterosexual (Contacts)	0
NIR#	0

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	0
20 - 29	10
30 - 39	9
40 - 49	6
50 - 59	1
60 or more	0

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	0
Kaposi's Sarcoma	0
Pneumocystis Carinii and Kaposi's Sarcoma	10
Other Diseases	16

AIDS IN ARKANSAS
1985 - 1990

Total number of cases reported	278
Number of deaths	170

CASES BY SEX

Male	256
Female	22

CASES BY RACE

White	215
Black	61
Other	2

CASES BY RISK GROUP

Homosexual/Bisexual	185
Homosexual & IV Drug User	31
IV Drug User	27
Hemophiliac	2
Transfusion	13
Heterosexual (Contacts)	15
NIR#	5

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	3
20 - 29	91
30 - 39	124
40 - 49	39
50 - 59	13
60 or more	8

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	124
Kaposi's Sarcoma	11
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	137

Source: Arkansas Department of Health.

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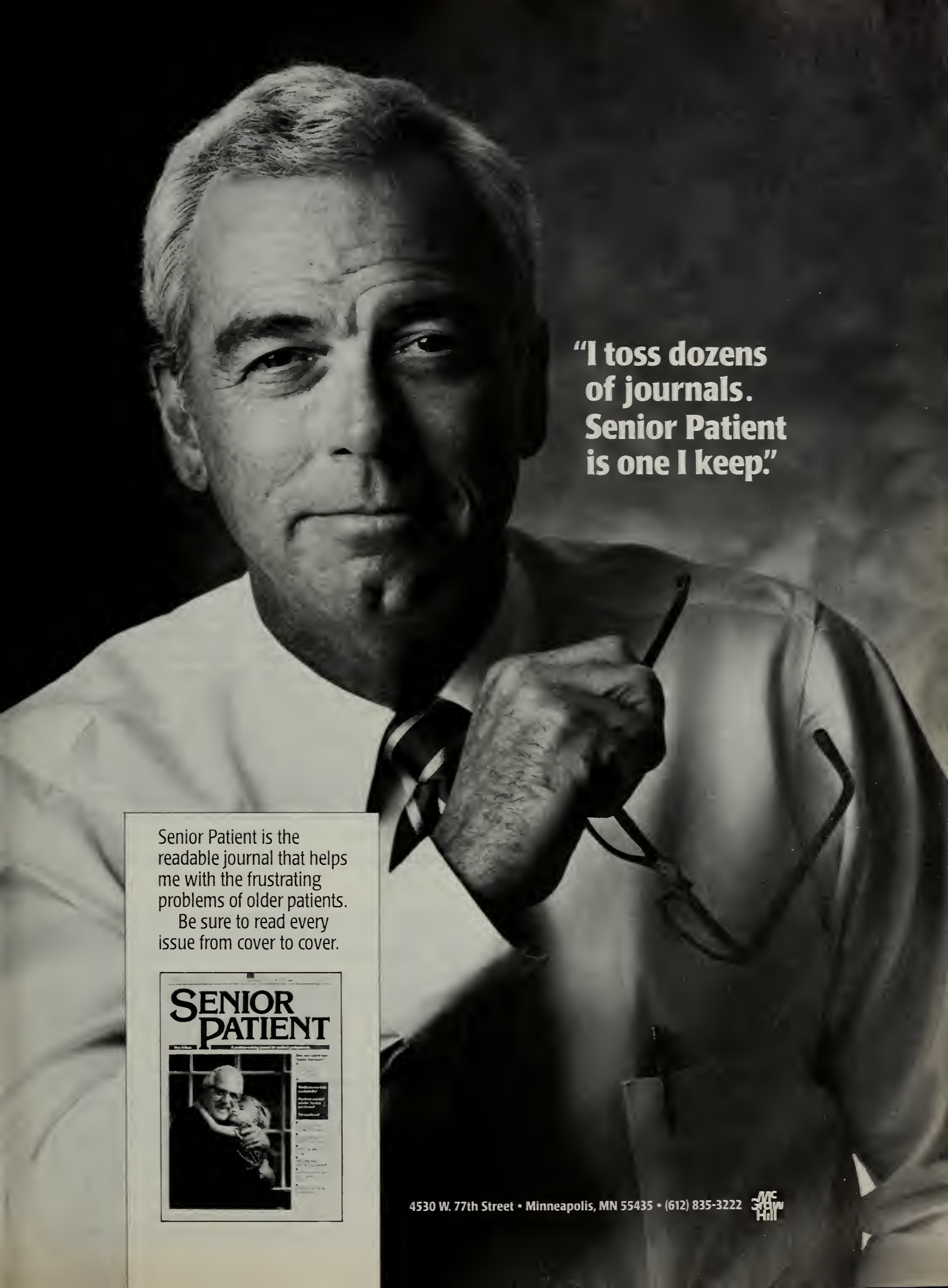
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Things To Come

April 18-22

10th Annual National Pediatric Infectious Disease Seminar and Special Session on A Preventive Approach to Medical Malpractice. Sponsored by the Department of Pediatrics, Southwestern Medical Center, Dallas, TX. Hyatt Regency Hotel, New Orleans, LA. Twenty-one Category I credit hours available for the Symposium and Seminar; 3 Category I credit hours for the Special Session. Fees: $350, physicians; $250, residents, Fellows, PA's and PNP's. For further information call (214) 688-8845.

April 23-27

Physician in Management I & II. Sponsored by the American College of Physician Executives, Tampa, FL. Cottonwoods Resort, Scottsdale, AZ. CME credit available. For more information, call 1 (800) 562-8088.

April 27-28

Sports Medicine for Physicians. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson at (606) 233-5161.

May 2-5

Ambulatory Surgery '90: Focus on Excellence. Sponsored by the Federated Ambulatory Surgery Association. Anaheim Marriott. For further information, contact Gail Durant, (703) 836-8808.

May 11-12

Lower Back & Sciatic Pain. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME Category I credit available. Fees: $250. For further information, contact Cathy Caruso at 1 (800) 325-9862.

May 16-19

The National Conference of Physician Executives. Sponsored by the American College of Physician Executives, Tampa, FL. Marriott Rivercenter, San Antonio, TX. CME credit available. For more information, call 1 (800) 562-8088.

May 19

Trauma Symposium. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington,KY. For further information contact Susan Gilson at (606) 233-5161.

May 20-26

21st Family Medicine Review - Session II. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson at (606) 233-5161.

May 25-27

Advances in Pediatrics. Presented by Catherine DeAngelis, M.D. (Ambulatory Pediatrics); Burton W. Fink, M.D. (Cardiology); Mark Sperling, M.D. (Endocrinology); Georges Peter, M.D. (Infectious Diseases); John E. Lewy, M.D. (Nephrology); Charles F. Weiss, M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Hilton Head Island, South Carolina. Sixteen Category I credit hours. Fees: $220, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016 and ask for CME Registration.

June 1-2

3rd Annual Contact Lens Course. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 6-9

Facial Rejuvenation. Sponsored by the Washington University School of Medicine, St. Louis, MO. Ritz-Carlton St. Louis Hotel. CME credit available. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 6-10

7th Annual Meeting of the Southern Orthopaedic Association. Sponsored by the Southern Orthopaedic Association, Birmingham, AL. Hyatt Regency Hotel, Maui, Hawaii. Category I CME credits available. For further information, contact Kathy McLendon at 1 (800) 423-4992.

June 7-9

Frontiers in Endosurgery: Flexible Endoscopy, Laser Surgery and Endourological Techniques. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. FOR UROLOGISTS ONLY. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 11-15

Physician in Management I & II. Sponsored by the American College for Physician Executives, Tampa, FL. Four Seasons Hotel, Philadelphia, PA. CME credit available. For more information, call 1 (800) 562-8088.

June 21-25

The AMA Hospital Medical Staff Section 15th Assembly Meeting. Sponsored by the American Medical Association. Chicago Marriott Hotel in Chicago, IL. For further information, contact the AMA at (312) 645-5000.

June 22-24

Clinical Pediatrics. Presented by Richard J. Summers, M.D. (Allergy); Barton D. Schmitt, M.D. (Behavioral Pediatrics); Sidney Hurwitz, M.D. (Dermatology); William F. Balistreri, M.D. (Gastroenterology); Ellen R. Wald, M.D. (Infectious Diseases); R. James McKay Jr., M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Washington, D.C. Fees: $200, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016.

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References

1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

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Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

PV 2098 AMP [091289]

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Keeping Up

Ophthalmology Update 1990

April 27, 8:00 a.m. - 4:30 p.m. Presented by Baptist Medical Center, Medical Affairs and the Arkansas Ophthalmology Institute. J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. Five and one-half Category I credit hours. Fees: $50, physicians; $25, nurses, pharmacists, and other allied health professionals.

Inflammatory Bowel Disease in Children

May 2, 12:00 noon. Presented by the Fort Smith AHEC. Fourth floor Conference Room, Sparks Regional Medical Center, Fort Smith. One Category I credit hour. No charge.

Epilepsy: Diagnosis and Treatment

May 25, 8:30 a.m. - 4:00 p.m. Presented by the Arkansas Children's Hospital. Sponsored by Abbott Laboratories, Ciba-Geigy, and Parke-Davis Laboratories. Arkansas Children's Hospital Auditorium, Little Rock. Six Category I credit hours. Fee: $25.00.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, varying topics, May 11 and May 25, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center, One Category I credit per meeting

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

CARTI Tumor Conference, first Wednesday, 12:00 noon, CARTI Auditorium. Lunch is served.
Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. Sandwich buffet served.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
General Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. Lunch is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Surgery Journal Club, Mondays, 12:00 noon, Operating Room Conference Room (2 Northwest). Sandwich buffet served.
Interdisciplinary AIDS Conferernce, second Friday, 12:00 noon, LaHarpe Room. Sandwich buffet is served.
Peripheral Vascular Disease Conference, first Tuesday, 5:30 p.m., Conference Room 1. Refreshments are provided.
GYN/Oncology Conference, second Monday, 12:00 noon, location to be announced. Lunch provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.

Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH
Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Rom G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
*Urology Morbidity and Mortality Conferen*ce, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute

VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, May 11, 15, 25; June 8 and 22, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Cherokee Village CME Conference, May 16; June 13, 12:00 noon, Baptist Memorial Hospital Cafeteria, Cherokee Village
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided
Cleburne County Medical Society, second Thursday, 12:00 noon, Cleburne Memorial Hospital - Herbert L. Thomas Conference Room, Heber Springs
Eaker AFB CME Conference, second and third Wednesday, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
West Plains CME Conference, fourth Wednesday, 6:30 p.m., West Plains Country Club, West Plains, MO
White River Medical Center CME Conference, May 18 & 24; June 21, 12:00 noon, Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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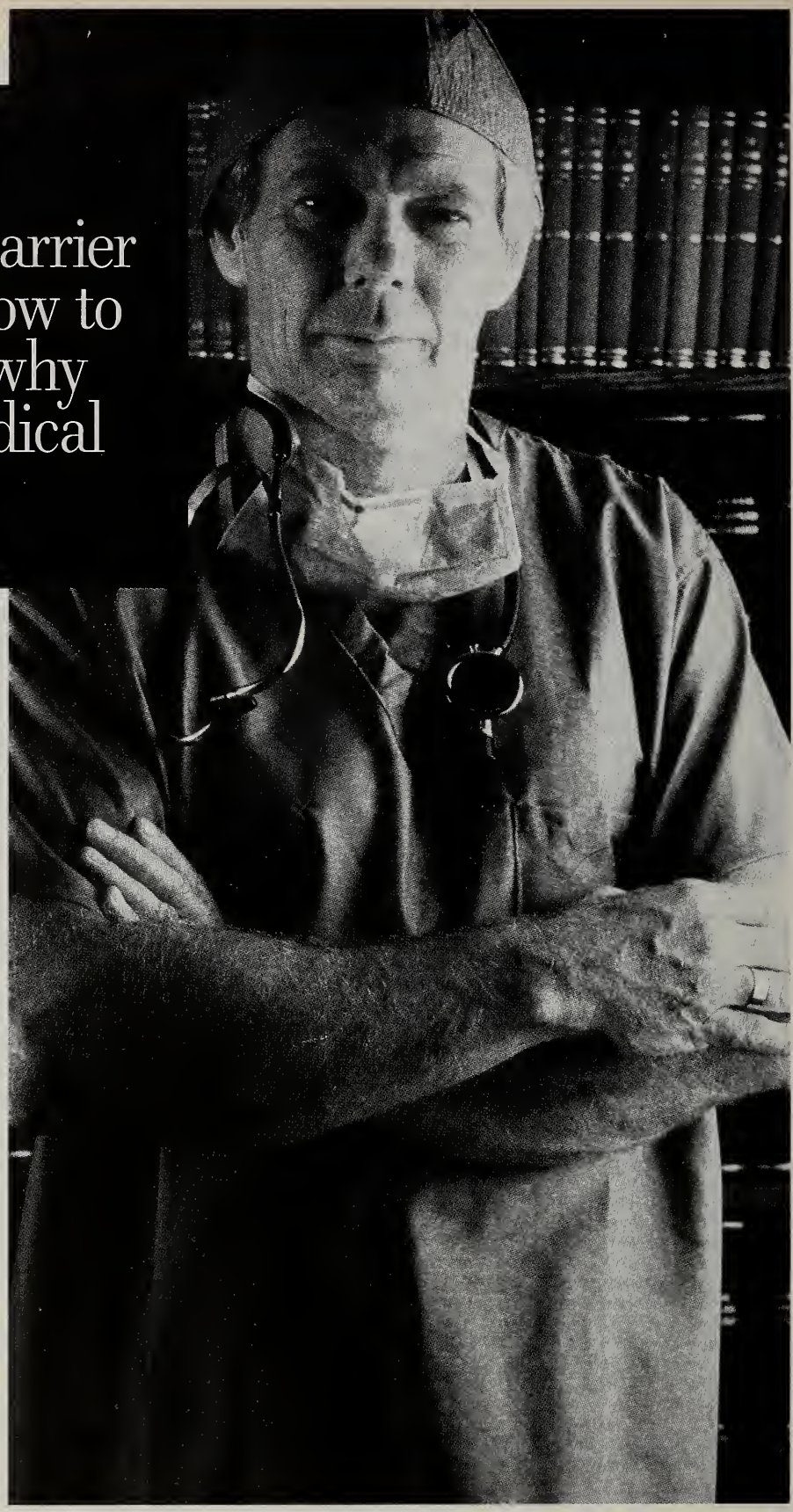
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In Memoriam

John S. McKinney, M.D.

John Schuler McKinney, of El Dorado, chief of staff and pediatrics at Warner Brown Hospital and Union Medical Center, died Thursday, February 27, 1990. He was 78.

Dr. McKinney was a member of the American Medical Association, the Arkansas Medical Society, and the American Acedemy of Pediatrics. He was an Army veteran of World War II.

Dr. McKinney is survived by his wife, Ruth Adkisson McKinney; a son, John Schuler McKinney Jr. of El Dorado; a daughter, Mary McKinney Edwards of Loveland, CO.; and a brother, Yost McKinney of El Dorado.

Woodbridge E. Morris, M.D.

Woodbridge Edwards Morris, a noted Little Rock physician, died Saturday, February 17, 1990. He was 87.

Dr. Morris was a member of the Arkansas Medical Society's Committee on Aging, the Pulaski County Council on Aging, the Arkansas Society of Internal Medicine, and the Arkansas Lung Association. He was a life member of the American College of Physicians and the Southern Medical Association, and was a fellow of the American Geriatric Society.

Dr. Morris is survived by his wife, Dorothy Heverin Wells Morris; two sons, John Wells Morris of Austin, TX., and Daniel Wells Morris of Little Rock; two daughters, Barbara M. Fisher of Thousand Oaks, CA., and Joan M. Jones of Dayton, OH; two brothers, Daniel L. Morris of Seattle, WA., and Charles L. Morris of Grove Beach, CT.; two sisters, Martha M. Vaughn of Booth Bay, MN., and Elizabeth M. Jackson of Glove AZ.; 14 grandchildren and two great-grandchildren.

H.R. Black Jr., M.D.

Hal Reed Black Jr., M.D., of Little Rock, chief of urology at the John L. McClellan Memorial Veterans Hospital and chief of staff at the old Baptist Hospital, died Sunday, March 18, 1990. He was 66.

Dr. Black was an Army Air Corps veteran, a colonel in the National Guard, and a member of several civic organizations.

Dr. Black is survived by his wife, Ann H. Black; a son, Hal Black III of Little Rock; a daughter, Katherine Ann Bishop of Little Rock; his father, Hal R. Black Sr. of Little Rock; a sister, Juanita Winn of Hot Springs; and three grandchildren.

Resolution

Woodbridge E. Morris, M.D.

Whereas, the recent death of our esteemed colleague, Woodbridge E. Morris, M.D., is noted sincere sorrow, and

Whereas, he had been a loyal member of this organization for forty-two years, giving generously of his time and effort to promote the interests of this Society, and

Whereas, Dr. Morris distinguished himself as a leader both academically and clinically in his chosen field of internal medicine.

RESOLVED, that this resolution be made part of the permanent records of this Society, and

RESOLVED, that a copy of this resolution be forwarded to Dr. Morris' family as an expression of our sincere sympathy, and

RESOLVED, that a copy of this resolution be forwarded to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
February 21, 1990

By Order of the Memorials Committee
Marlon Doucet, M.D., Chairman
Henry Hollemberg, M.D.
Robert Watson, M.D.



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AIR FORCE

New Members

ARKANSAS/ST. FRANCIS COUNTY

Conner, George L. III, Family Practice, Forrest City. Born May 22, 1952, Memphis, TN. Pre-medical education, Memphis State University, Memphis, TN, 1978. Medical education, University of Tennessee, Memphis, TN, 1984. Internship/residency, Baptist Memorial Hospital, Gadsden, AL, 1987. Practice experience, 2 years. Board certified. Member, American Academy of Family Practioners-Arkansas.

CRAIGHEAD/POINSETT COUNTY

Barrett-Tuck, Rebecca, Neurosurgery, Jonesboro. Born August 3, 1956, London, KY. Pre-medical education, Arkansas State, Jonesboro, 1978. Medical education, UAMS, Little Rock, 1982. Internship, UAMS, Little Rock, 1983. Residency, University of Texas Health Science Center, San Antonio, TX, 1988. Practice experience, 2 years. Board eligible. Member, Congress of Neurosurgery, AANS.

Bartlett, Sylvan, Plastic & Reconstructive Surgery, Jonesboro. Born, September 20, 1937, Gordon, NE. Pre-medical education, University of Indiana, East Chicago & Gary Extensions, 1963. Medical education, University of Missouri School of Medicine, Columbia, MO, 1967. Internship/residency, Tampa General Hospital, 1970. Practice experience, 13 years. Board certified. Member, AMA, ASPRS, TMA, Lipoplasty Society of North America.

Landry, Robert J., Ophthalmology, Jonesboro. Born, April 23, 1944, Brooklyn, NY. Pre-medical/medical education, LSU, New Orleans, LA, 1975. Internship, Confederate Memorial Hospital, 1976. Residency, Eastern Virginia Medical School, 1979. Practice experience, 10 years. Board certified. Member, AMA, LMS, East Baton Rouge Paris Medical Society, Contact Lens Association of Ophthalmologist.

Peacock, Loverd M., Internal Medicine, Jonesboro. Born May 1, 1943, Tiptonville, TN. Pre-medical education, Harding College, Searcy, 1965. Medical education, University of Arkansas School of Medicine, Little Rock, 1970. Internship, University Hospital, Little Rock, 1971. Residency, University of Arkansas College of Internal Medicine and University of Utah College of Internal Medicine, 1973. Practice experience, 8 years. Member, American College of Radiology, American College of Physicians, AMA, American Society of Therapeutic Radiology & Oncology, American Society of Clinical Oncology.

DESHA COUNTY

Masquil, Filipe D., Internal Medicine, McGehee. Born September 4, 1942, Mozambique. Pre-medical education, Columbia University, New York, NY, 1969. Medical education, Freiburg Medical School, W. Germany, 1983. Residency, Perth Amboy General Hospital, NJ, 1989. Board eligible. Member, American College of Physicians.

FRANKLIN COUNTY

Wilson, Robert L., Family Practice, Ozark. Born, April 2, 1956, Beebe. Pre-medical education, UCA, Conway, 1977. Medical education, UAMS, Little Rock, 1982. internship/residency, AHEC, Fort Smith, 1985. Practice experience, 4 1/2 years. Board certified. Member, AAFP.

HOWARD/PIKE COUNTY

O'Bryan, Deborah S., Emergency Medicine, Murfreesboro. Born February 3, 1959, Pine Bluff. Pre-medical education, University of Arkansas, Pine Bluff, 1980. Medical education, UAMS, Little Rock, 1986. Internship, AHEC, El Dorado, 1987. Practice experience, 1 year.

MISSISSIPPI COUNTY

Rhodes, Joseph B., Family Practice, Osceola. Born September 2, 1960, Osceola. Pre-medical education, Baylor University, Waco, TX, 1982. Medical education, UAMS, Little Rock, 1986. Internship/residency, John Peter Smith Hospital, Fort Worth, TX, 1989.

PULASKI COUNTY

Atkinson, William E. Jr., Pathology, Little Rock. Born January 22, 1937, Fordyce. Pre-medical education, Arkansas A&M, 1962. Medical education, UAMC, Little Rock, 1967. Internship/residency, UAMC, Little Rock, 1971. Practice experience, 19 years.

Ball, Charles W. Jr., Family Practice, Little Rock. Born, November 4, 1951, Lake Village. Pre-medical education, Tulane University, New Orleans, LA, 1973. Medical education, UAMS, Little Rock, 1977. Internship, University Hospital, Little Rock, 1978. Residency, LSU Charity Hospital, New Orleans, LA, 1980. Board certified. Member, AMA, Christian Medical Society, Southern Medical Society, AAFM, ACEP.

Billie, James D., Otolaryngology, FPS, CS, Little Rock. Born, February 12, 1948, Wakefield, MI. Pre-medical education, University of Michigan, Ann Arbour, MI, 1967. Medical education, University of Texas, Houston, TX, 1976. Board certified.

Crawford, Cary M., Family Practice, Little Rock. Born, July 4, 1959, Benton. Pre-medical education, ASU, Jonesboro, 1981. Medical education, UAMS, Little Rock, 1985. Internship/residency, AHEC, Pine Bluff, 1988. Board certified.

Fisher, Robert A., Emergency Medicine, Little Rock. Born, April 1, 1957, Little Rock. Pre-medical education, LSU, Baton Rouge, LA, 1978. Medical education, UAMS, Little Rock, 1978. Internship/residency, UAMS, 1987. Board certified.

Fuller, Clinton J. III, Radiology, Little Rock. Born May 20, 1951, Nashville, AR. Pre-medical education, University of Arkansas, Fayetteville, 1972. Medical education, UAMS, Little Rock, 1976. Internship/residency, UAMS, 1980. Board certified. Practice experience, 10 years.

Hamilton, George E. Jr., Psychiatry & Neurology, Little Rock. Born, April 8, 1940, Urbana, IL. Pre-medical education, Columbia, New York, NY, 1961. Medical education, Boston University School of Medicine, Boston, MA, 1965. Internship/residency, University of Utah Affiliated Hospitals, Salt Lake City, UT, 1966; Mass. Mental Health Center, Boston, MA, 1969. Certification pending. Practice experience, 22 years.

Jackson, Thomas R., General Practice, Little Rock. Born December 23, 1952, Pine Bluff. Pre-medical education, University of Arkansas, Little Rock, 1977. Medical education, University of Arkansas College of Medicine, Little Rock, 1984. Internship/residency, University Hospital, Little Rock, 1985. Board certified.

Leou, Frank, OB/GYN, Little Rock. Born, May 25, 1936, Taipei, Taiwan. Medical education, National Defense Medical Center, Taipei, Taiwan, 1962. Board eligible.

Maners, Ann W., Therapeutic Radiology, Little Rock. Born September 31, 1952, Rock Hill, SC. Pre-medical education, Furman College, Greenville, SC, 1974. Medical education, Medical University of South Carolina, Charleston, SC, 1980. Internship/residency, Medical University of South Carolina, Charleston, SC, 1984. Board certified. Practice experience, 5 years.

McFarland, Cortez E., OB/GYN, North Little Rock. Born, July 27, 1945, Newton, MS. Pre-medical education, Tougaloo College, MS, 1967. Medical education, University of Iowa, Iowa City, Iowa, 1974. Internship/residency, San Bernardino County Medical Center, San Bernardino, CA, 1978. Board certified. Practice experience, 12 years.

Shotts, Joseph F., Family Practice, Jacksonville. Born, October 9, 1957, Mobile, AL. Pre-medical education, University of Arkansas, Little Rock, 1982. Medical education, UAMS, 1986. Internship/residency, UAMS, 1989. Board certified.

Stephens, Wanda J., Psychiatry, North Little Rock. Born, January 12, 1934, Little Rock. Pre-medical education, Hendrix College, Conway, 1954. Medical education, University of Arkansas School of Medicine, Little Rock, 1958. Internship, St. Vincent Infirmary, Little Rock, 1959. Residency, Austin State Hospital, Austin, TX; Arkansas State Hospital, Little Rock, 1965. Board certified. Member, Arkansas Psy. Society, American Psy. Society. Practice experience, 25 years.

Stout, Kimber M., Cardiology, Little Rock. Born, June 21, 1945, Little Rock. Pre-medical education, Hendrix College, Conway, 1966. Medical education, UAMC, Little Rock, 1970. Internship, University of Oregon, Portland, OR, 1971. Residency, UAMC, 1975. Board certified.

SEBASTIAN COUNTY

Builtman, James L., Radiology, Fort Smith. Born, May 20, 1954, Jackson, MS. Pre-medical education, Hendrix College, Conway, 1976. Medical education, UAMS, 1984. Residency, UAMS, 1988. Pending certification.

Burks, Deland D., Radiology, Fort Smith. Born, October 1, 1954, Guntersville, AL. Pre-medical education, Vanderbilt University, Nashville, TN, 1980. Medical education, Vanderbilt University School of Medicine, 1980. Internship, University of Alabama Medical Center, Birmingham, AL, 1981. Residency, Vanderbilt University, 1984.

Cain, Martin W., Radiology, Fort Smith. Born, August 25, 1956, Tyler, TX. Pre-medical education, Texas A&M, College Station, TX, 1978. Medical education, University of Texas Southwestern Medical School, Dallas, TX, 1982. Internship/residency, St. Joseph's Medical Center, Waco, TX, 1989. Board certified.

Franz, F. Perry, Plastic & Reconstructive Surgery, Fort Smith. Born September 16, 1958, Liberty, TX. Pre-medical education, OSU, Stillwater, OK, 1979. Medical education, University of Oklahoma College of Medicine, 1983. Internship/residency, Michigan State University, Butterworth Hospital, Grand Rapids, MI, 1988. Board eligible.

WASHINGTON COUNTY

Ternes, Justin A., Child Psychiatry, Fayetteville. Born, September 14, 1954, St. Louis, MO. Pre-medical education, University of Arkansas, Fayetteville, 1978. Medical education, UAMS, 1982. Internship/residency, UAMS, 1987. Board certified. Member, American Academy of Child Psychiatrists.

WHITE COUNTY

Thompson, Bruce A., OB/GYN, Searcy. Born, January 27, 1956, Natchitoches, LA. Pre-medical education, Louisiana Tech University, 1978. Medical education, LSU School of Medicine, Shreveport, LA, 1982. Internship/residency, LSU Hospital, Shreveport, LA, 1986. Practice experience, 3 years. Board eligible. Member, AMA, Jr. Fellow, ACOG.

Wulz, Curtis E., Emergency Medicine, Searcy. Born, September 13, 1961, Duncan, OK. Pre-medical education, Hendrix College, Conway, 1983. Medical education, University of Kansas, Kansas City, KS, 1987. Internship/residency, Pitt Co. Memorial Hospital, Greenville, NC, 1989.

RESIDENT SECTION

Mason, Richard H., Family Practice, El Dorado. Born, July 22, 1959, Melbourne, FL. Pre-medical education, Rollins College, Patrick Air Force Base, FL, 1980. Medical education, Universidad Mundial (World University), Santo Domingo, Dominican Republic, 1988. Internship/residency, AHEC, El Dorado.

AMS NewsMakers

David L. Stewart, M.D., of Benton, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians (AAFT).

Benjamin H. Hall, M.D., of Prairie Grove, was appointed chief of staff at Fayetteville City Hospital. Dr. Hall established a medical practice in west Washington county and serves as the only physician with an office based in Lincoln.

Keith Dixon, M.D., of North Little Rock, has been named to the board of directors of Goodwill Industries of Arkansas, Inc. Dr. Dixon is a nephrologist with dialysis centers in Searcy, Conway, and North Little Rock.

P. Vasudevan, M.D., of Helena, has been named "Citizen of the Year" by the Chamber of Commerce of Phillips County. He is a past president of the Phillips County Medical Society.

Robert Miller Jr., M.D., a Helena physician, has been reappointed to the executive committee of the Arkansas State Board of Health. The reappointment marks Dr. Miller's eighth year to serve on this committee.

Allan S. Pirnique, M.D., has been named campaign chairman of Union County's American Heart Association 1990 fund-raising drive in El Dorado.

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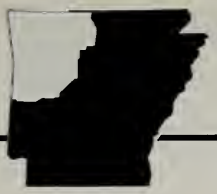


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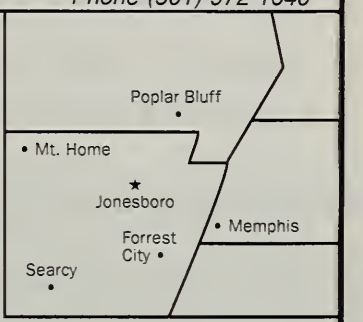
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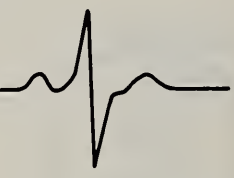
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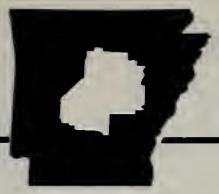
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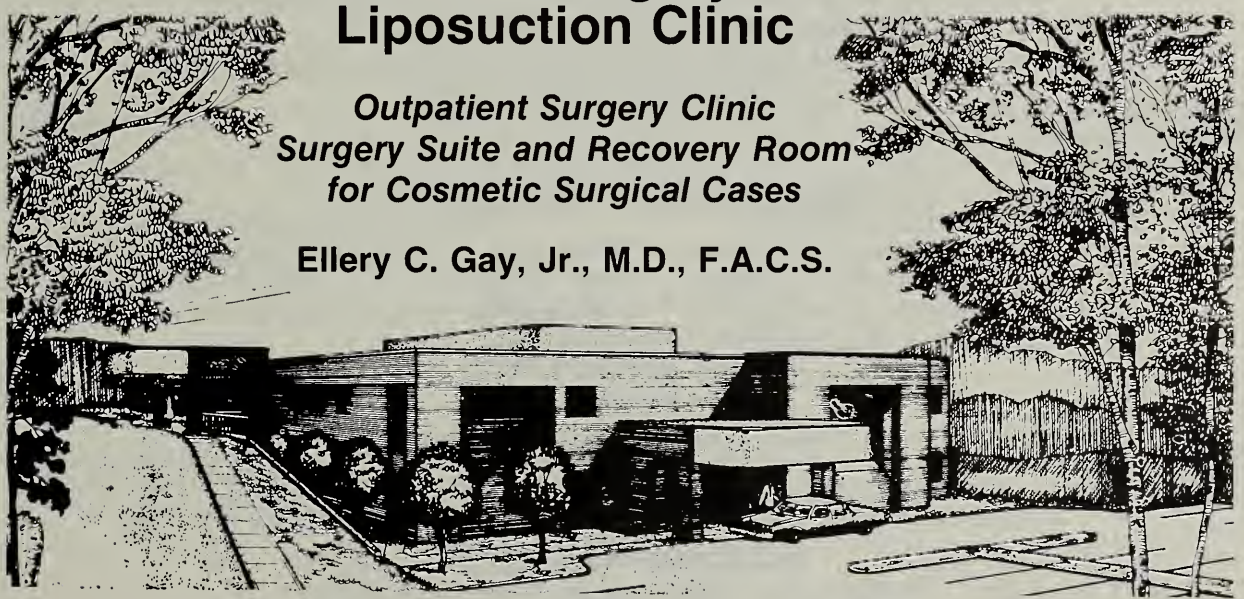
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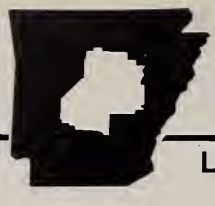
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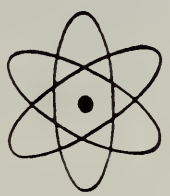
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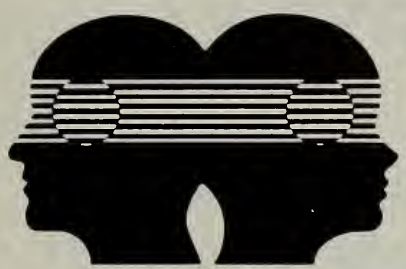
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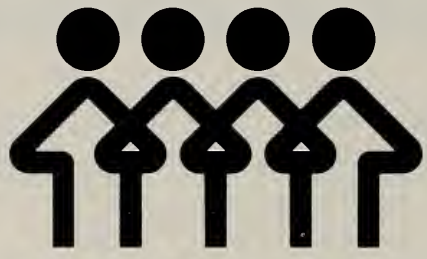
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Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASDTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASDTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASDTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATIDN.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy–Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASDTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances, atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings.

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIDNS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASDTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

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Exclusion Of Fertile Women From The Workplace: Bad Medicine, Worse Law

Donald R. Mattison, M.D.*

Many believe that job discrimination based on gender is, if not immoral, at least illegal. That, however, may soon change. The 7th Circuit Court of Appeals has decided 7-4 in favor of a company which bans fertile women from certain jobs. The company, Johnson Controls, Inc., decided in 1982 to exclude women from work environments containing lead ostensibly because of fear of fetal damage. Women under the age of 70 were allowed to work if they provided medical evidence of sterility. At least one woman had surgical sterilization performed in order to retain her job. Women barred from these jobs subsequently sued Johnson Controls, Inc. The suit claimed that the policy violated the prohibitions against sex and pregnancy discrimination provided by Title VII of the Civil Rights Act.

One of the dissenting jurists, Judge Frank Easterbrook, has called this "...the most important sex discrimination case in any court since 1964..." when congress enacted Title VII of the Civil Rights Act. As indicated by Easterbrook, this approach to occupational health protection has the potential to exclude as many as 20 million women from industrial jobs. The decision in this case stands in stark contrast to a Federal Regulatory decision taken by the Occupational Safety and Health Administration approximately one decade ago. In that case, a chemical which produces testicular toxicity was banned from use rather than excluding men from jobs with exposure. Clearly, divergent solutions to similar problems are being applied. The issues in this case fall into several arenas including, medical, scientific, economic, and legal. The medical and scientific issues will be reviewed in this editorial and a possible solution developed.

The medical and scientific issues in this case revolve around identification of the biological processes which are most sensitive to the toxicity of lead. Johnson Controls, Inc. argues that the developing fetal brain is the most sensitive. The argument, however, willfully ignores a large body of data demonstrating toxicity of lead to male reproduction, female reproduction, and the adult. The argument also ignores a substantial deficit in our knowledge about the effects of male mediated exposures on fetal development. In addition, other organ systems in the adult - both male and female - are sensitive to lead toxicity. Lead has been identified as a toxicant for more than 200 years. A substantial amount of information on male and female reproduction, fetal development and toxicity to the adult is available. This data indicates that male and female reproduction are sensitive to lead, as is the fetus and the adult. Therefore, at Johnson Controls, Inc., men are "allowed" to be exposed to a known toxicant while women who have the potential to become pregnant are excluded.

What data suggests that reproductive or developmental processes are most sensitive to toxic effects of chemicals? Several years ago, Koeter, a scientist with the Institute of Toxicology and Nutrition in the Netherlands reviewed toxicity data from 37 chemicals to determine the most sensitive end point. For 1/3 of the chemicals tested, reproductive or developmental end points appeared to be the most sensitive. For the other 2/3, reproductive and developmental parameters appeared to be no more sensitive than other toxicological end points. Looking more specifically at fetal effects, among a group of 3,000 chemicals tested for developmental toxicity, approximately 20% were positive in animals and 1% were positive in humans. These data suggest the importance of including reproductive and developmental end points in toxicity testing. However, it does not support the notion that any particular end point, including fetal development, is the most sensitive to toxicity. Rather, the data suggest that all end points need to be critically examined to define clearly the one most sensitive and for which occupational health protection policies need to be developed. Available data on lead do not permit a clear distinction of the most sensitive end point. A similar conclusion was also reached several years ago by the Occupational Safety and Health Administration - multiple end points appear equally sensitive to lead toxicity.

Do spontaneous abortion, congenital malformation or fetal toxicity occur only after exposure of the female? In

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general, these adverse reproductive outcomes are assumed to result from exposures to the female during pregnancy. However, this assumption does not reflect clear evidence demonstrating that male exposures have no effect on the fetus, as much as **lack of evidence**. In addition, experimental and epidemiological studies that have explored the impact of male mediated exposures on fetal effects have been subject to astonishing debate and scrutiny. This is because the data from those studies does not fit well into present scientific paradigms. In considering this issue, it is important to recall that reproduction is a couple mediated biological process. Many of us would have difficulty with arguments attempting to define whether males or females were more important in reproduction or which set of genes were most important. Clearly, both are needed and must act together for successful outcome.

Interestingly, there are data that suggest that interactions between male and female occupational exposures can be associated with adverse reproductive outcome. Studies conducted in Finland by Hemminki and his colleagues at the Institute of Occupational Medicine have suggested that spontaneous abortion occurs more frequently among women working in the textile industries, if their husbands work in the chemical industries. In this setting, who should be required to leave their job -- the male or female member of the couple, or should **both jobs be made safe for reproduction**? This is an important consideration for Johnson Controls, Inc. because data published by several research groups suggests that spontaneous abortion rates are higher among wives of lead workers. By ignoring other adverse health effects, and excluding women, Johnson Controls, Inc. risks liability by deliberate exposure of men to a known health hazard, including reproductive toxicity.

Simply identifying the fetus as the most sensitive biological process and excluding women from the workplace contaminated with lead is at best simplistic. Adverse effects **other than fetal development** have been demonstrated to occur at levels of lead exposure similar to those associated with fetal development. A survey of the toxicological effects of other compounds also suggests that fetal developmental end points are not always the most sensitive. In this setting, exclusion of women from the workplace seems capricious, or worse - discriminatory and threatens the health of male workers. Clearly defined assessment of risk for all toxicological end points is essential to protect all workers and their families. Excluding women simply because they may carry a fetus is short-sighted and may endanger working men and their offspring.

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Lupus Anticoagulant*

Paul E. Williams, M.D.**

Introduction

The term *lupus anticoagulant* is misleading because the majority of patients do not suffer from systemic lupus erythematosus, they do not bleed, and actually are predisposed to suffering from thrombotic events. It is the recognition of this latter risk that has renewed interest in detecting and correctly diagnosing patients with a lupus anticoagulant. The following case illustrates a patient with this disorder. A brief discussion of the possible mechanisms of action, and the management strategies are then presented.

The abnormality produced by the lupus anticoagulant is due to immunoglobulins (usually IgG, IgM, or a mixture of both) which interfere with invitro phospholipid-dependent coagulation tests (e.g., prothrombin time (PT), partial thromboplastin time (PTT), and Russell viper venom time (RVVT)). These antibodies do not specifically inhibit any of the coagulation factors, rather they appear to be directed at phospholipids in general.

Lupus anticoagulants were first noted in 1952 when Conley and Hartman described two patients with systemic lupus erythematosus and prolonged whole blood clotting time and prothrombin time. In 1959, Medal and Lisker summarized the clinical and laboratory manifestations of 16 patients with a prolonged prothrombin time, but is was not until 1972 that Feinstein and Rappaport attached the name *lupus anticoagulant* to this syndrome. It was, however, an unfortunate misnomer since, as noted above, the majority of patients *do not* suffer from systemic lupus erythematosus as defined by the American Rheumatological Association, but rather from a lupus-like syndrome, and in the absence of other hemostatic abnormalities, the patients *do not* bleed. Initially, lupus anticoagulants were regarded by clinicians and laboratory researchers as a nuisance. The findings of an unexplained prolonged PTT often led to a series of factor assays and other studies of the coagulation system which were frequently inconclusive. However, the recent association of lupus anticoagulant with various clinical complications, including arterial and venous thromboembolic disease and spontaneous abortions, sparked a renewed interest in detecting and correctly diagnosing a lupus anticoagulant.

It is now recognized that a lupus anticoagulant is found not only in patients with systemic lupus erythematosus but also a variety of clinical conditions including autoimmune diseases, drug exposure, infectious diseases, and malignancies (Table I). Although the presence of this disorder in patients with autoimmune disease has been well documented, only 6% to 50% of patients with systemic lupus erythematosus have this disorder. Lupus anticoagulants secondary to drugs comprise approximately 12% of all the reported cases of lupus anticoagulants. Chlorpromazine is by far the most common cause of drug induced lupus anticoagulant making up approximately 87% of the drug related cases followed by procainamide (6%), and Hydralazine (4%). These figures represent the percent of drug-induced cases that have been reported and not the percent of patients who will get a lupus anticoagulant secondary to the drug. Considering how many patients are on procainamide, the actual number who will develop a lupus anticoagulant is much lower than 6%. In the majority of cases with drug induced lupus anticoagulant, the

Table I
Clinical Conditions Associated with Lupus Anticoagulant

I. Autoimmune diseases
   - A. Systemic lupus erythematosus
   - B. Rheumatoid arthritis
   - C. Others, including "overlap" syndromes

II. Drug exposure
   - A. Cholrpromazine
   - B. Procainamide
   - C. Hydralazine
   - D. Quinidine
   - E. Antibiotics
   - F. Phenytoin

III. Infections
   - A. Bacterial
   - B. Protozoan (*Pneumocystis carinii*)
   - C. Viral

IV. Lymphoproliferative disorders
   - A. Hairy cell leukemia
   - B. Malignant lymphoma
   - C. Waldenstrom's macroglobulinemia

V. Miscellaneous disorders
   - A. Epithelial malignancies
   - B. No underlying disease

* Presented at the regional meeting of the American College of Physicians, October 1989. This paper was chosen for the award given by the Little Rock Diagnostic Clinic for the best paper presented by an Associate member.

** Dr. Williams is with the Department of Medicine, UAMS, Little Rock, Arkansas.

antibody isotype has been IgM and there has been no apparent thrombotic predisposition. Usually with discontinuation of the offending drug the lupus anticoagulant will disappear, but this is not always true as the following case illustrates.

Case Report

A 38-year-old white male presented to the McClellan VA Hospital with a two day history of left calf pain, which began suddenly. Thinking this to be a "pulled muscle" the patient applied heat to his leg and rested it. His left calf began to swell so the patient sought medical attention. He denied any recent trauma to his leg, long car rides, or recent surgical manipulations of his leg. His past medical history is significant for excessive alcohol usage, anemia felt to be multifactorial in nature, hypertension, and degenerative joint disease. The patient was first diagnosed with hypertension in 1978. He was initially treated with Aldomet but because of depression was switched to Hydralazine in 1978. In December 1988, while the patient was being evaluated for chronic anemia and prior to a colonoscopy, he was noted to have a PTT of 62. An antinuclear antibody (ANA) and mixing studies were performed at that time. The ANA was 1:640 with a homogenous pattern and the mixing studies failed to correct the PTT, so the patient was thought to have a lupus anticoagulant secondary to the Hydralazine; this drug was discontinued in January 1989.

Physical examination at the time of admission revealed a blood pressure of 150/80, pulse of 64, and a respiratory rate of 12. The remainder of his physical examination was only significant for pale conjunctiva, pale mucous membranes, and a left calf measuring four centimeters larger than the right calf and the left thigh measuring two centimeters larger than the right thigh. No palpable cords were appreciated in his left leg.

Laboratory evaluation revealed a hemoglobin of 7.7 and a hematocrit of 24% with a platelet count of 407,000. Electrolytes were all within normal limits and the creatinine was 0.7. The prothrombin time was 13 seconds, and his partial thromboplastin time was 63 seconds. Further studies revealed that he was iron deficient and had a reticulocyte count of 2.4 which when corrected for his anemia was 1.4. A venogram performed at the time of admission demonstrated a deep venous thrombosis of the left leg extending to the confluence of the superficial saphenous vein and the deep system. He was initially treated with intravenous heparin and Coumadin orally, and switched to Coumadin solely after four days. Because his PTT was already extended, it was elected to try and prolong his PTT to 1.5 times the original measurement. A workup for lupus anticoagulant was undertaken and it revealed an ANA of 1:640 with a homogeneous pattern, an erthrocyte sedimentation rate of 63, and a platelet neutralization procedure that was positive. Mixing studies were performed but they failed to correct his PTT. A negative rheumatoid factor and VDRL were obtained and anticardiolipin antibodies of the IgG, IgM, and IgA isotype were searched for but none were detected. Based on the above data the patient was felt to have a lupus anticoagulant and was felt to need long-term anticoagulant therapy. He was discharged to home on Coumadin 5 milligrams every day. The patient has remained on Coumadin 5 milligrams every day and at six month follow up had experienced no further thrombotic events.

Discussion

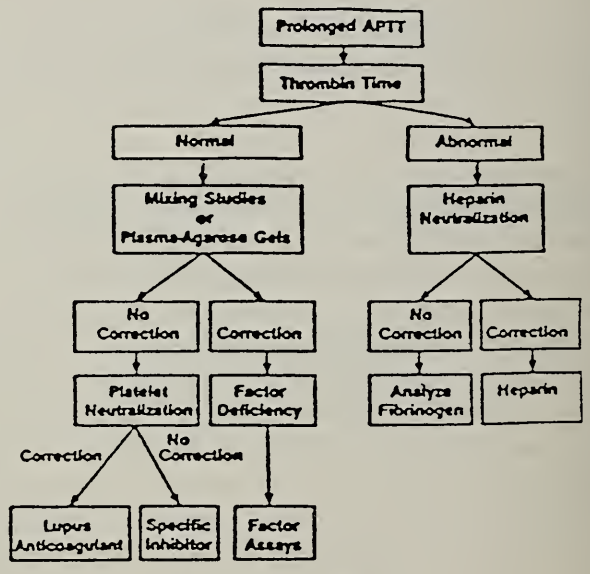
In most instances, the presence of lupus anticoagulant is initially suspected by an unexplained prolongation of the PTT. However, before a diagnosis of lupus anticoagulant can be made, three minimal criteria should be met:

1. An abnormality of the phospholipid-dependent coagulation reactions (PT, PTT, RVVT) must be demonstrated.

2. The abnormality is due to an inhibitor and not specific factor deficiencies.

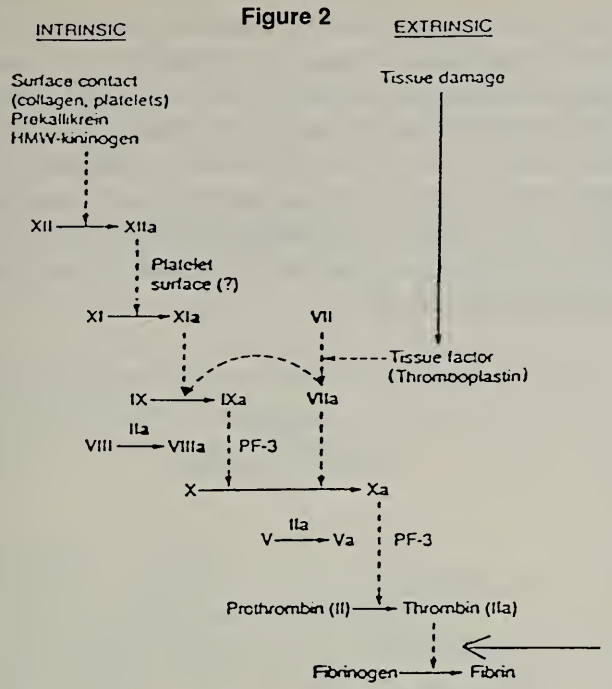
3. The inhibitor activity is directed at phospholipid in general (not specific factors).

If one has a prolonged PTT, a simple algorithm can help evaluate what is causing this (Figure 1). Once a prolonged PTT is discovered, a thrombin time should be performed. The thrombin time measures the latter sequences of the coagulation cascade; i.e., fibrinogen to fibrin monomer to



Algorithmic approach for the evaluation of an unexplained prolonged APTT. A thrombin time performed early in the evaluation is helpful to rule out heparin effect, a common cause of a long APTT in hospitalized patients. Mixing studies and/or plasmagarose gels are useful to differentiate inhibitor effect from deficiency states. The platelet neutralization procedure or another confirmatory test can then differentiate LA from specific factor inhibitors.

Figure 2



The intrinsic pathway is initiated when blood comes in contact with the negatively charged de-endothelialized vascular surface. Factor XII is activated, and, in a sequential reaction, factors XI and IX are activated. On the platelet surface, factors IXa and VIII interact with calcium and activate factor Xa. In the extrinsic pathway, tissue thromboplastin is released after vessel wall injury activates factor VII, which in turn activates factor X. Then, on the platelet surface, factors Xa and Va interact with calcium and catalyze the conversion of prothrombin to thrombin. Thrombin converts fibrinogen to fibrin polymers in the developing clot. Note that factor VII from the extrinsic pathway may activate factor IX in the intrinsic pathway.

initial clot, but it does not examine the final factor VIII medicated cross linking (Figure 2, arrow). The thrombin time is prolonged when fibrinogen is low or structurally abnormal or in the presence of anticoagulants such as heparin. If the thrombin time is abnormal, the serum should be neutralized for heparin. If the thrombin time is abnormal, the serum should be neutralized for heparin and if this does not correct the thrombin time, then one may conclude that the fibrinogen is either structurally abnormal or present in insufficient quantity. If the thrombin time is normal, mixing studies, using four parts patient's serum and one part normal serum, should be performed to look for a factor deficiency (i.e., factors VIII, IX, XI, XII). A correction of the thrombin time after mixing studies indicates a factor deficiency and specific assays should be performed to determine which factor and/or factors are deficient. If the mixing studies fail to correct the thrombin time, a platelet neutralization procedure should be preformed. The precise mechanism of the platelet neutralization procedure is confirmation of the presence of a lupus anticoagulant. Specific antibodies to factors (i.e., factor II) are present if the thrombin time is still abnormal after the platelet neutralization procedure.

Several clinical complications are associated with a lupus anticoagulant, the most common being venous and arterial thromboses. The association of lupus anticoagulant and thrombosis was first proposed in 1963 by Bowie, et al. Since that time, the cumulative literature has shown that approximately 30% of patients with lupus anticoagulant will have at least one thrombotic event in their lifetime. Of all of the thrombotic events, approximately one-third are arterial in nature, occurring primarily in the cranial arteries and manifesting as transient ischemic attacks and cerebral vascular accidents. However, peripheral arteries can be involved causing livedo reticularsis and widespread skin necrosis. The remaining two-thirds of thrombotic events occur in the venous system, usually in the legs, manifesting as deep venous thrombosis with no prior history of trauma, surgery, or other risk factors. Multiple small emboli, manifesting as pulmonary hypertension, are common but it is not clear if this is secondary to a clot in a leg or primary event.

Several risk factors have been identified that increase an affected person's chance of developing a thrombus (Figure 3). The chance for thrombosis is increased in adults when one's prothrombin level is normal, the platelet count is greater than 50,000, the levels of anticardiolipin antibodies are greatly increased, and the immunoglobulin class of the lupus anticoagulant is IgG (+/-) IgM. There is a correlation between raised levels of anticardiolipin antibodies and thrombosis. Lechner and associates found that raised levels of anticardiolipin antibodies were found in 40 of 65 (61%) of patients with systemic lupus erythematosus but raised levels were found in 29 of 32 (91%) patients with systemic lupus erythematosus and the presence of a lupus anticoagulant. Of the 29 patients with systemic lupus erythematosus and a

Figure 3

Possible risk factors for thrombosis in patients with LA

	HIGHER RISK	LOWER RISK
Age	> 10 years	< 10 years
Prothrombin level	normal	reduced (<50%)
Platelet count	> 50,000/ul	< 50,000/ul
Anticardiolipin antibody	greatly increased	normal
Immune Globulin class of LA	IgG (+/- IgM)	IgM

lupus anticoagulant, 15 had some type of thrombotic event. They concluded that the presence of high levels of anticardiolipin antibodies may be a useful marker for the risk of thrombosis in patients with lupus anticoagulant alone and not systemic lupus erythematosus. Thrombotic events appear to be selective as there is only one case of retinal vein thrombosis and one case of renal vein thrombosis reported. It also appears that there is no increased risk for coronary thrombosis in patients with a lupus anticoagulant. Other clinical complications associated with lupus anticoagulant are thrombocytopenia, for which the exact mechanism is unknown, biologically false/positive test for VDRL, ANA, and Coombs reaction, and recurrent abortion. The association of lupus

anticoagulant and recurrent abortion was first reported in 1975 by Nilsson. He noted that fetal growth retardation, first trimester abortion, and unexplained death in the second and third trimester were seen more frequently in women with the lupus anticoagulant. In many cases the placenta was found to have extensive infarction causing the miscarriage.

The exact mechanism of action of the lupus anticoagulant and its ability to cause thrombosis has not been fully resolved but there are five possible theories: their effect on 1) platelets, 2) prostacyclin production, 3) endothelial cells, 4) prekallikrein activity, and 5) protein C activation. Lupus anticoagulants have been shown to stimulate the production of thromboxane A-2 by platelets. Thromboxane A-2 is a potent inducer of platelet aggregation and constrictor of arterial smooth muscle.

A second hypothesis has been based on a possible interaction between the autoantibodies and endothelial cell membrane phospholipids. Carreras, et al postulated that these phospholipid antibodies could disrupt the arachadonic acid pathway and inhibit production of prostacyclin, a potent vasodilator and inhibitor of platelet aggregation. They showed that immunoglobulins obtained from a patient with a history of recurrent arterial thrombosis, repeated abortions, and a lupus anticoagulant reduced the release of prostacyclin from rat aorta or pregnant human myometrium. This inhibitory effect was abolished by addition of arachnoidic acid. Carreras hypothesized that the reduction in prostacyclin formation in vessel walls led to an increase in the aggregability of platelets facilitating the development of venous and arterial thromboses.

An alternative hypothesis has been put forth by Angles-Cano, et al. They have shown that the sera from several patients with lupus anticoagulant inhibited prekallikrein activity, thereby, interfering with fibrinolysis and facilitating clot formation (Figure 4).

One of the main inhibitors of intravascular coagulation is a complex involving thrombomodulin, an endothelial cell membrane-bound protein, and thrombin. This complex, in conjunction with phospholipid and calcium, are potent activators of protein C. Protein C then functions as an anticoagulant by inactivating two of the regulatory proteins in the coagulation pathway, factors Va and VIIIa. Three different laboratories have recently shown that the IgG fraction of sera from patients with lupus anticoagulant interferes with the interaction between thrombin, protein C, and thrombomodulin on the surface of endothelial cells. This results in inhibition of protein C activation and a decrease in anticoagulant activity (Figure 5).

Figure 4

Activation of the Fibrinolytic System

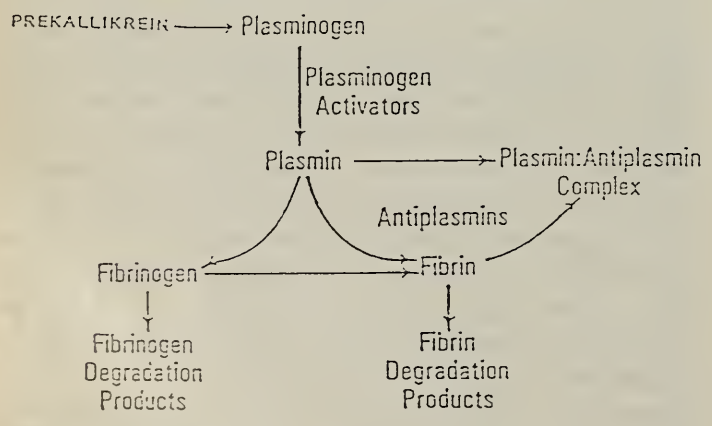
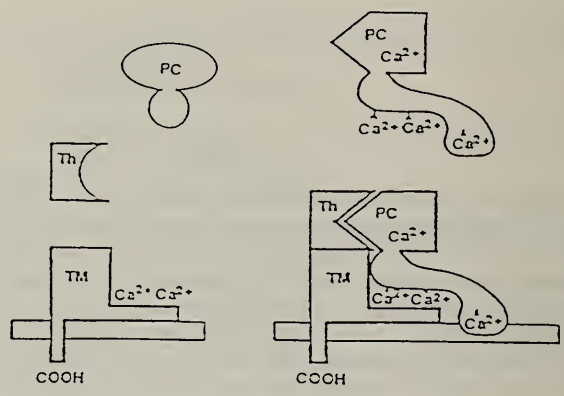


Figure 5

Protein C Activation



Management

Because a lupus anticoagulant may be transient or persist for years, the presence of a lupus anticoagulant in an otherwise asymptomatic patient is currently not an indication for anticoagulant or immunosuppressive therapy. However, if a patient develops transient ischemic attacks or evidence of pulmonary hypertension, they should receive anticoagulant or antiplatelet medication. The presence of a lupus anticoagulant in a patient who is to undergo surgery or who will be confined to a bed for a long period may warrant the use of low-dose heparin prophylaxis. Patients with lupus anticoagulant who present with venous or arterial thrombi should be treated initially with heparin and subsequently with an oral anticoagulant. Once a patient with lupus anticoagulant has experienced a thrombotic event, the patient may be considered a candidate for long-term oral anticoagulant therapy.

Pregnant women who have a lupus anticoagulant should be treated with prednisone (60 milligrams per day) combined with low-dose aspirin (75 milligrams per day) until the birth of the child. Lubbe et al were the first to use this regimen and they were able to achieve 10 live births in 16 high risk pregnancies. The prednisone does not correct the PTT and is not a cure for the lupus anticoagulant. It is used to try and suppress the lupus anticoagulant activity until the child is born.

Summary

Lupus anticoagulants have been recognized as significant causes of morbidity in patients for many years. They were originally regarded by physicians and researchers as a nuisance. However, the name is a misnomer that has resisted change over the years. The riddle of the anticoagulant effect in vitro and the apparent procoagulant effect in vivo remains unsolved. Since a lupus anticoagulant can exist in virtually every patient population, it is no longer a topic of interest limited only to the hematologists, but has achieved multidisciplinary attention. The presence of a lupus anticoagulant should be evaluated in any patient who presents with new onset transient ischemic attack or cerebral vascular accident, unexplained deep venous thrombosis, or recurrent fetal wastage.

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AIDS IN ARKANSAS 1990
January 1 - December 31, 1990

Total number of cases reported	39
Number of deaths	13

CASES BY SEX

Male	35
Female	4

CASES BY RACE

White	33
Black	6
Other	0

CASES BY RISK GROUP

Homosexual/Bisexual	26
Homosexual & IV Drug User	6
IV Drug User	3
Hemophiliac	2
Transfusion	0
Heterosexual (Contacts)	2
NIR#	0

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	1
20 - 29	17
30 - 39	15
40 - 49	6
50 - 59	0
60 or more	0

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	14
Kaposi's Sarcoma	0
Pneumocystis Carinii and Kaposi's Sarcoma	0
Other Diseases	25

AIDS IN ARKANSAS
1985 - 1990

Total number of cases reported	291
Number of deaths	182

CASES BY SEX

Male	266
Female	25

CASES BY RACE

White	225
Black	64
Other	2

CASES BY RISK GROUP

Homosexual/Bisexual	190
Homosexual & IV Drug User	33
IV Drug User	30
Hemophiliac	2
Transfusion	14
Heterosexual (Contacts)	18
NIR#	4

No identified risk group (NIR)

CASES BY AGE GROUP

Less than 20	4
20 - 29	98
30 - 39	130
40 - 49	39
50 - 59	12
60 or more	8

OPPORTUNISTIC DISEASE

Pneumocystic Carinii	128
Kaposi's Sarcoma	11
Pneumocystis Carinii and Kaposi's Sarcoma	6
Other Diseases	146

Source: Arkansas Department of Health.

Management of the Psychiatric Aspects of HIV Infection

Charles K. Billings, M.D.*

Anxiety, depression, dementia, and delirium are the most common psychologic manifestations of HIV infection. Anxiety symptoms commonly occur in the early stages of infection when the otherwise asymptomatic seropositive patient tries to adjust to and accept the prospect of a life-threatening illness. The anxious seropositive patient may have generalized free-floating anxiety, overt episodic panic attacks, hypochondriacal preoccupation with bodily symptoms, or obsessive rumination about the illness. Pharmacologic treatment of these symptoms include benzodiazepines or buspirone (BuSpar). Actual panic attacks usually respond to treatment with alprazolam (Xanax) or clonazepam (Klonopin). Psychologic management of anxiety is perhaps even more important with emphasis on a healthy lifestyle, stress management, good nutrition, physical exercise, and avoidance of illicit drugs, cigarettes, and unprotected sexual activity. A recent study suggests that individuals who have just learned of their seropositive state do not necessarily have increased risk of suicidal thoughts or suicide, but clinical vigilance about this possibility should never be relaxed throughout the course of HIV infection.[1]

More and more "worried well" patients are coming to physicians with concerns or even convictions about having HIV infection. Some of these people are actually members of high-risk groups and have reason to be concerned, while others have no history of high-risk behavior but simply become obsessed with the likelihood of infection. This obsession can even reach delusional proportions, requiring antipsychotic medication and even hospitalization in some cases.

Depression is common in HIV infected individuals. Guilt seems to be ubiquitous, with rumination about lifestyle or behavior which predisposed to infection and the possibility of having infected loved ones.[2] It is difficult to tell whether vegetative symptoms of fatigue, malaise, anorexia, and weight loss are due to major depression or HIV infection itself. Antidepressants low in sedating potential and anticholinregic side effects have anecdotally worked best with HIV patients, especially those with overt AIDS and its accompanying neuropsychologic dysfunction. Fluoxetine (Prozac) is activating without significant anticholinergic or cardiovascular side effects and has been successful with many patients. Prescribing fluoxetine every other day works well for some patients because of the long half-life and the possibility of agitation or "overactivation" if given daily. Methylphenidate (Ritalin) has also worked well with AIDS patients in doses as low as 5 mg BID. Advantages include immediate effects, noticeable activation, and no anticholinergic side effects. Concerns about dependency are obviously negligible in dying individuals who deserve relief from their suffering. Desipramine (Norpramin, Pertofrane) in doses as low as 10 mg once or twice a day has also been recommended for depressed AIDS patients.

The major risk of depression in patients with AIDS is suicide. Suicide attempts and completed suicides are clearly increased in AIDS patients.[3] A number of suicides occur impulsively in a hospital setting, suggesting the possibility of judgement-impairing delirium as a contributing factor. The highest risk of suicide seems to be early in the course of AIDS, when the diagnosis has just been learned, and then late in the course, when neuropsychologic impairment or delirium may impair judgement.

Dementia, punctuated by episodes of delirium, commonly accompanies AIDS.[4] As many as 60% of AIDS patients have AIDS dementia. HIV itself has been cultured from the brains of AIDS patients, and many neuropsychiatric symptoms are therefore caused by HIV infectious encephalopathy. AIDS even occasionally "presents" as delirium, and the possibility of HIV infection should be part of the differential when organic symptoms of dementia are soon accompanied by motor signs and symptoms, and the AIDS patient may die mute, paralyzed, and incontinent. Episodes of agitation and delirium may require treatment with antipsychotic medication. Low doses of the potent neuroleptics (e.g., 1-2 mg daily or BID of halperidol [Haldol]) work best, avoiding oversedation and anticholinergic side effects. In fact, the psychopharmacologic treatment of all AIDS pa-

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tients should be viewed as similar to that of geriatric patients. The reason for this is the prevalence of HIV infection of the brain itself, dictating lower doses of all psychotropics and increased vigilance to side effects and paradoxical reactions. Benzodiazepine treatment of anxiety or agitation is best accomplished with short-acting benzodiazepines such as alprazolam (Xanax) or lorazepam (Ativan), thereby avoiding excess accumulation of drug, which can cause oversedation and impaired motor activity.

The psychotherapeutic management of AIDS patients requires that the clinician be available, accessible, and nonjudgemental. Simply "being there" is very important to many AIDS patients who have been abandoned by family, friends, and colleagues. "Following the patient's lead" is also important by not imposing on him or her your notion of how to cope with dying and death, but respecting the patient's notion and pace, timing your comments and interventions to coincide with the patient's requests and needs. Helping the patient make decisions about a will, finances, and resuscitation measures may also be part of the task. The focus of the clinician should not be on conquering or even necessarily facing death, but rather on enhancing the quality of life still remaining. Clinicians who are not afraid to help AIDS patients psychologically cope can provide the opportunity for patients to maintain dignity and integrity in the face of such a devastating illness.

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Meningitis: An Unusual Case of Misdiagnosis

Cindy Conkle, R.N., ARM*

Meningitis strikes children of all ages, not just infants. And, as the case history illustrates, the patient may not present the typical physical symptoms.

Case History

A 14-year-old girl was brought to a hospital emergency room with a sore throat, earache, slight fever and one vomiting episode. The examination revealed bilateral injection tympanic membranes with vesicles. The pharynx was red and inflamed, but without exudate. The neurologic exam revealed a supple neck, negative Kernig's sign and negative Brudzinski's sign. She was diagnosed with bullous myringitis and acute pharyngitis. The ER physician prescribed erythromycin and Tylenol #3 and recommended a follow-up visit to an otolaryngologist.

The child improved slightly after taking medication for two days. However, on the third day, she began vomiting and her fever stayed just below 100 degrees F. The next day the child vomited each time the medication was given. The mother noticed the child's eyes were crossing and she couldn't look straight ahead. The patient also began to complain of a stiff neck.

Early the next morning, the girl was taken back to the hospital because the mother believed that her child might have meningitis. The child's pulse and respirations were elevated, and she complained of dizziness and a stiff neck. The ER nurse noted that the child was hyperventilating, complained of pain in both ears and bled from the left ear.

The physician examined the patient and found her condition essentially the same as on the previous visit. The girl's neck was supple and she had a negative Kernig's sign. He believed that the girl had bullous myringitis and acute pharyngitis that were not responding to the antibiotic because of vomiting. The physician prescribed the same medicines, a phenergan suppository and recommended plenty of fluids. A demerol and phenergan injection was given for pain. Upon discharge, the child's respirations and pulse were normal.

That evening, the child tried to get out of bed and fell down. Her mother put her back to bed, but later found her lying on the floor semiconscious, with drainage from both ears. The child was immediately returned to the emergency room. She was admitted to the ICU and was brain dead within 48 hours.

The autopsy showed probable cause of death to be ischemic insult and brain stem herniation due to intracranial pressure caused by meningitis (fusobacterium nechrophorum). The case settled out-of-court at a cost of more than $250,000.

Claim Data

In 1989, 9,701 cases of aseptic meningitis and 2,517 cases of meningococcal infection were reported, according to the December 22, 1989 issue of ***Morbidity and Morality Weekly Report***. During 1984-89, St. Paul policyholders had a relatively low percentage of meningitis cases as compared to all emergency service-related claims. While the frequency of meningitis claims is not impressive, the severity (cost per claim) is high. These claims had an average cost in excess of $100,000. The severity of these claims is due to the debilitating results or deaths of patients with undiagnosed meningitis.

Risk Management Tips

The following risk management guidelines may be useful in diagnosing meningitis cases that present in the emergency room:

* Do not automatically rule out the possibility of meningitis in children with acute myringitis or otitis media.

* Question the family about minor neurological changes such as loss of coordination and crossed eyes.

* Do a thorough follow up examination on patients who

* Ms. Conkle is Associate Risk Management, Health Care Manager with St. Paul Fire and Marine Insurance Company, Little Rock, Arkansas.

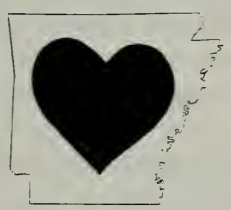
return to the emergency room with no improvement and rethink the diagnosis.

* Use a follow up system to call patients that have been put on antibiotics without cultures, to determine the effectiveness of the antibiotic chosen. Also review the discharge instructions with the patient. In the case history, for example, the physician might have urged the patient to visit an otolaryngologist.

* Document all findings - the negative as well as the positive ones.

* Do appropriate lab tests and a lumbar puncture for a definitive diagnosis when in question regarding meningitis.

Some patients who present to the emergency room with meningitis will not have the typical physical symptoms. Many will have ear infections and acute pharyngitis. Taking special precautions with these young patients to appropriately rule out meningitis can prevent mental and physical debilitation and death.



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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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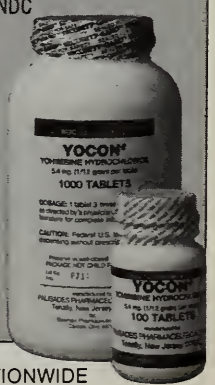
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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Introduction

The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) included a number of changes to the Medicare Program. Below is a detailed summary of those charges effective April 1, 1990, with particular emphasis in charge limits for "overpriced" procedures and charge limits to designated specialties.

The application and impact of the designated specialty rule will vary across the country and by specialty. Not all Medicare carriers paid specialty differentials. Reductions for certain procedures in some localities may be high. The AMA is conducting an impact analysis to be used in pursuing legislation and regulatory relief. The AMA will be able to make a stronger case to HCFA and on Capitol Hill if they are armed with actual case examples. Therefore, the AMA is asking state and national specialty societies to supply them with information on reductions for individual services, the impact on particular specialties and group practices or clinics.

April 1990 Medicare Program Changes Enacted in the Omnibus Budget Reconciliation Act of 1989

Passage of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) including three key Medicare physician payment reform provisions: (1) a five-year transition to a new payment schedule based on an RBRVS beginning in 1992; (2) a three-year transition to new balance billing limits beginning in 1991; and (3) the establishment of Medicare volume performance standards (MVPS) beginning this year. In addition, the OBRA 1989 legislation also included a number of other new Medicare program changes, many of which will be implemented on April 1, 1990. A summary of these changes is presented below.

Sequestration Extension

Effective April 1, 1990, the 2% sequestration will be replace by a 1.4% sequestration "reduction" in payments through the end of the fiscal year.

Medicare Economic Index (MEI) Increase

Effective April 1, 1990, the MEI increase is as follows:

* 4.2% increase for primary care services (CPT codes 90000-90170, 90300-90580, 92002, and 92004).
* 0% increase for radiology, anesthesia, and "overpriced" services (in addition, the conversion factors used to compute fee schedules for radiologists' services (excluding portable x-ray services) are reduced by 4%).
* 2% increase for other physician services.

Maximum Allowable Actual charge (MAAC) Updates

1990 MAACs are updated as follows:

* If a 1989 MAAC is equal to or greater than 115% of the 1990 prevailing charge level for nonparticipating physicians, the 1990 MAAC equals 101% of the 1989 MAAC.
* If the 1989 MAAC is less that 115% of the 1990 prevailing charge level for nonparticipating physicians, the 1990 MAAC equals the greater of: 101% of the 1989 MAAC or 115% of the 1990 prevailing charge for nonparticipating physicians.

Customary Charges for "New" Physicians

Effective April 1, 1990, the customary charges of new physicians (physicians for whom adequate charge data are not yet available) are limited to 80% and 85% of the prevailing charges in each locality in the physicians's first and second years, respectively. These limits do not apply to primary care services or to services rendered in health manpower shortage areas. Previously, customary charges for new physicians were limited to the lower of the 50th percentile of weighted customary charges. In 1989, these limits were set at 80% of the prevailing charge levels for the first year of practice. In subsequent years, these physicians' customary charges were based on their own actual charges.

Limits on Actual and Prevailing Charges for "Overpriced" Procedures

"Overpriced" physician procedures and services are defined as those that had 1989 prevailing charges that were at least 10% greater than preliminary resource-based payment schedule estimates developed by the Physician Payment Review Commission (i.e., reduced national average prevailing amounts). Approximately 250 "overpriced" procedures and services were identified. Physicians who have 1990 prevailing charges that are reduced by this provision should have received the changes with their "Dear Doctor" letter.

Effective April 1, 1990, the prevailing charge for identified "overpriced" procedures for participating and nonparticipating physicians will be reduced by the lesser of:

* 15% of the 1989 prevailing charge, or
* 1/3 of the percent by which the 1989 prevailing charge

exceeds the Locally-Adjusted Reduced Prevailing Amount (LARPA).

LARPAs are calculated by multiplying reduced national average prevailing amounts by geographic practice cost indexes (GPCIs) for each payment locality. (Note: variation in LARPAs reflect only variation in the physician "overhead" portion of the reduced national average prevailing amounts).

As an example, assume that the 1989 prevailing charge for an "overpriced" procedure was $1,000 and the LARPA for a given locality is $800.

* 15% of the 1989 prevailing charge is $150
* 1/3 of the percent by which the 1989 prevailing charge exceeds the LARPA is 8.33%, or $83.30
- The 1989 prevailing charge exceeds the LARPA by 25%
  ($1,000 - $800 = $200)
  ($200/$800 = 25%)
- 1/3 of 25% is 8.33%

The 1990 prevailing charge for this procedure would be $916.70 ($1,000 - $83.30) because $83.30 is a smaller reduction than $150. (A nonparticipating physician's prevailing charge would be 5% less, or $870.86.)

In addition, nonparticipating physicians providing "overpriced" services that are subject to these reductions will face MAACs and "special" charge limits for these services that will be calculated as follows:

* 125% of the nonparticipating "reduced" prevailing charge, plus
* 1/2 of the amount by which the physician's MAAC for the procedure for the previous 12-month period exceeds the 125% level.

In such cases, the lower of the MAAC or the "special" charge limit will serve as the physician's actual charge limit.

Limits on Actual and Prevailing Charges to Designated Specialties

Effective April 1, 1990, for a number of high volume surgical, radiological and diagnostic physician services, the prevailing charge for participating and nonparticipating physicians will be limited to the prevailing charge (or fee schedule amount) for the specialty that provides the service most frequently nationally. Physicians who have 1990 prevailing charges that are reduced by this provision should have received the changes with their "Dear Doctor" letter. (Note: This limitation applies only when a Medicare carrier recognizes specialty differentials in the calculation of prevailing charges for a service.)

Similar to "overpriced" procedures, nonparticipating physicians providing services whose prevailing charge levels are reduced as a result of the designated specialty provision, will be subjected to both MAACs and "special" charge limits that will be calculated as follows:

* 125% of nonparticipating "reduced" prevailing charge, plus
* 1/2 of the amount by which the physician's MAAC for the service for the previous 12-month period exceeds the 125% level.

Once again, the lower of the MAAC or the "special" charge limit will serve as the nonparticipating physician's actual charge limit.

In addition, it should be noted that payment reductions due to the designated specialty provision will be applied after reductions have been made as a result of the "overpriced" procedure provision. Thus, the overall reduction for a procedure or service subject to both provisions could exceed 15%. (Note: 92 of the 250 "overpriced" procedures are subject to the designated specialty provision.)

Special Payment Method for Nuclear Medicine Physicians

Effective April 1, 1990, physicians who submitted charges for nuclear medicine services that accounted for at least 80% of their total Part B charges from July 1, 1988 to June 30, 1989, will be paid based on a blend of 1/3 of the radiology fee schedule amount for the procedure in the locality and 2/3 of 101% of the 1988 prevailing charge level amount for the procedure in the locality.

Time Units for Anesthesia Services

Effective April 1, 1990, fractional time units for anesthesia services will be based on actual time instead of being "rounded" to the next full time unit.

Limitations on Charges for Medicare Beneficiaries Eligible for Medicaid Benefits

Effective April 1, 1990, payment on an assigned basis will be required for physician services provided to individuals enrolled under Medicare who are eligible for Medicaid to purchase their Medicaid coverage but not otherwise eligible for Medicaid (Qualified Medicare Beneficiaries, or QMBs). Assignment currently is required for Medicare beneficiaries who are actually enrolled in a state Medicaid program. QMBs are individuals with incomes below the federal poverty level but not eligible for Medicaid.

Related Issues

* Local Code Collapsing - During March 1990, the Health Care Financing Administration (HCFA) began an initiative to collapse or eliminate special local carrier codes as part of its standardization plan to implement the new Medicare physician payment schedule based on the RBRVS. Carriers were to have notified physicians of local code changes by February 15, 1990. The impact of this initiative will vary due to

differences in carrier use of local codes.

* Participation Agreements - "Dear Doctor" letter, accompanied by physician charge screens and charge limit data reflecting the changes discussed above, were to have been mailed by carriers no later than February 28, 1990. Physician who have not received this information should contact their carrier immediately. Physicians experiencing difficulties in obtaining such information from their carrier may contact the AMA Washington Office for assistance. Participation decisions must be made by March 31, 1990.

* Carrier-Assigned Provider Identification Numbers - "Rendering and performing" physicians are reminded that they must include their local carrier-assigned provider identification number (PIN), not to be confused with the unique physician identification numbers (UPINs) on all Medicare claims. Effective May 1, 1990, assigned claims without carrier-assigned PINs will be rejected, while unassigned claims will be developed (i.e, investigated) for the missing PINs. Assigned claims that are rejected for missing PINs should be resubmitted rather than pursued through the appeals process. Group practice physicians should use both their group PINs and their individual PINs provided by the carrier.

OB/GYN - Fourth OB/GYN to join very busy 20 man multi-specialty group in a historic Midwestern town. Birthing rooms and 24 hour anesthesia availability. Fully equipped 120 bed hospital, many recreational and civic activities. Competitive starting salary and benefits package with productivity bonus and partnership potential. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

Orthopedic Surgeon - Second orthopedic surgeon sought to join very busy 20 man multi-specialty group in Midwest community. Interest in back surgery a plus. Fully equipped professionally staffed P.T. department at 120 bed hospital; excellent school system, many recreational and civic activities. Competitive starting salary and benefits package with productivity bonus and partnership potential. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

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Group Management for the 90's

Terry Brown, President, AMGMA

Running a successful group practice becomes more difficult and demanding every year.

As the complexities of managing personnel, making financial decisions and dealing with third party payments and everyday collection problems have grown, the office manager of yesterday has evolved into a skilled professional - the group practice administrator.

The vast majority of Arkansas physicians still manage their own practices. But as more physicians join forces to reduce administrative expense, contain their overhead and realize the other benefits of group practice, the job of administering the larger practice becomes far more taxing and time consuming.

Medical schools in the past have taught little or nothing about the art of practice management. And in many ways, managing people and organizations interferes with the things physicians must do to maintain their practices.

More and more, group practices have begun hiring managers or retaining outside practice management consultants to take care of their operations. In some cases, one of the group's physicians becomes the practice manager and receives compensation for those duties.

Usually, however, a professional administrator is hired or retained part-time to perform the practice management function.

State Association Dedicated to Improvement

The Arkansas Medical Group Management Association (AMGMA) was formed in 1972 by a dedicated group of practice administrators to help them promote the successful management of physician's practices throughout the state.

The AMGMA's by-laws set out the Association's aims, which include improvement of business and health care administration, sharing information about legislative matters and health care management, promoting member education and providing lay activities for medical groups.

Though it is affiliated with the national Medical Group Management Association, membership in the state association does not automatically bring membership in the national group.

The AMGMA does maintain liaison with the MGMA and with the American College of Medical Group Managers, which extends educational credit for seminars, courses and other training the AMGMA conducts.

From its initial group of four founders, the AMGMA grew to 15 its second year and now has over 150 members on its roster.

The group generally meets four times a year, usually with a strong educational or informational purpose to its meetings.

Topics in the past have included personnel management, relations between physicians and their practice managers, collection of receivables and legal and political issues affecting medical groups.

Some recent speakers at AMGMA functions have included Michael Kurtz, a nationally recognized speaker on physician-manager relations; U.S. Rep. Tommy Robinson; U.S. Sen. David Pryor; State Rep. Jim Keet; Republican gubernatorial candidate Sheffield Nelson; and assorted officials from Blue Cross and Blue Shield, state regulatory agencies and Medicare-Medicaid.

The current AMGMA board includes Terry Brown, administrator of Burton-Eisele Clinic, P.A. of Hot Springs, as president; Pamela Skinner, administrator of Parker Orthopaedics of Van Buren, as vice president; June Schnider, administrator of Pearson, Bledsoe and Costaldi, P.A. of Rogers, as secretary; and Phil Deloney, administrator of TCS Orthopaedic Clinic of Little Rock, as treasurer.

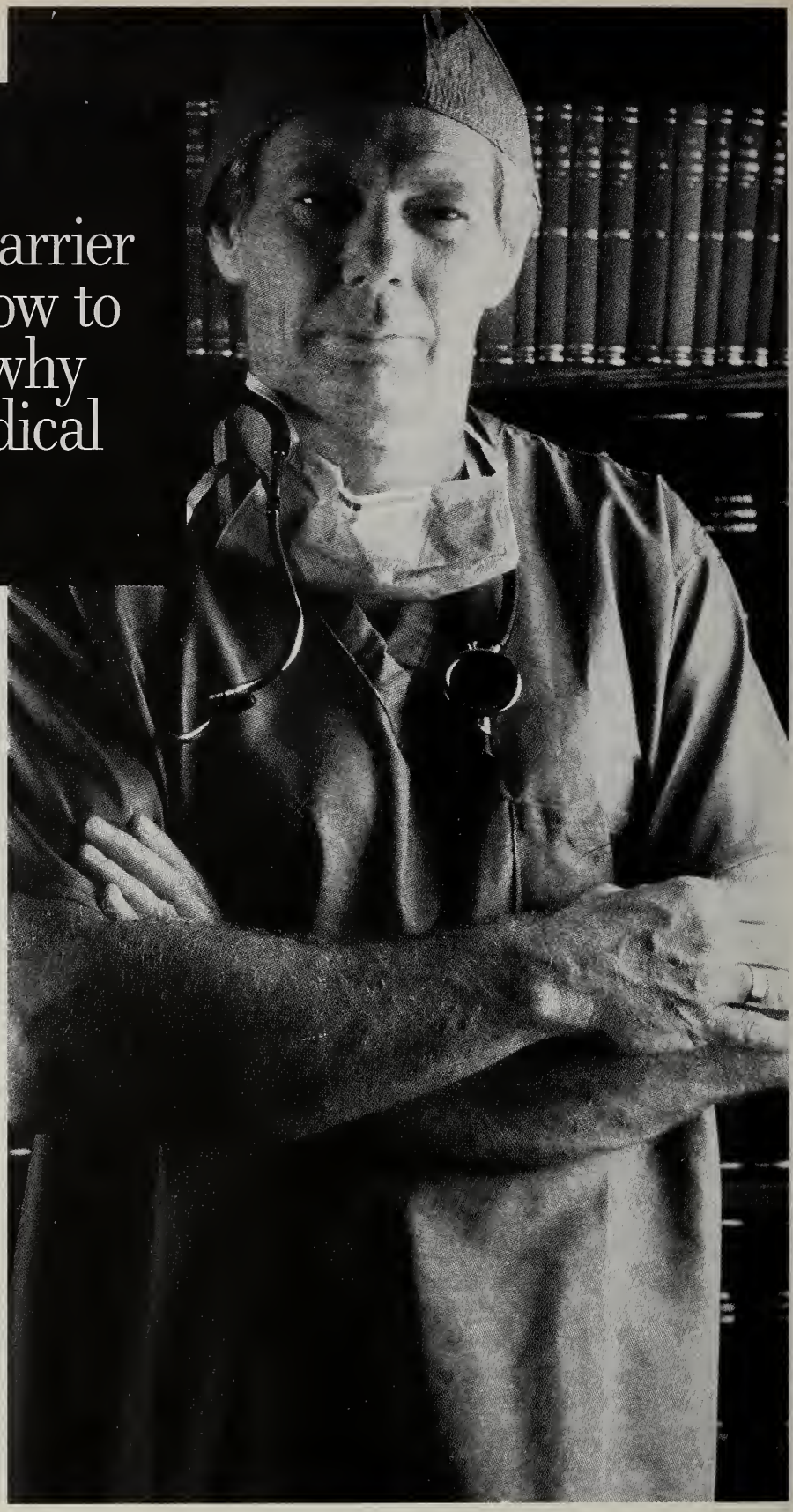
The organization recently developed a new graphic image and began an aggressive drive for new members. Since the first of the year, 30 new members have joined the AMGMA.

A well-publicized meeting on the medical profession's problems with third-party payors drew 90 attendees to Little Rock to hear private insurance companies, regulatory agencies an others present their views on how to cope with the problems of third-party payment.

Legislative issues affecting the way medical groups do business are the topics at the group's May meeting at the State Capitol, and "Group Management for the Nineties" will be the subject of the AMGMA annual meeting at Little Rock's Capitol Hotel in August.

Dues are $30 per year, and membership belongs to the clinic or medical practice rather than the administrator. For further information or a membership application, contact Mr. Brown at (501) 321-2229 in Hot Springs or Mr. Deloney at (501) 664-7710 in Little Rock.

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The PRO Contract - What Exactly Is It?

Russell G. Brasher, Ph.D.*

"A monster horrifying, formless, immense."
–Virgil: The Aeneid, III

The Arkansas Foundation for Medical Care, Inc, is the Peer Review Organization (PRO) for Arkansas, so designated by contract with the Health Care Financing Administration. As such, it reviews medical services provided to Medicare beneficiaries throughout the state. Most physicians and hospitals (and other health care facilities) have come into contact with some aspect of this review. Few, however, are aware of the full extent of the PRO's activities and few could say where and how these activities are delineated.

It's all in the contract. But what exactly is the contract, what kind of document is it? Is it ten pages or a hundred? Could we publish it in this journal? In this article I will attempt briefly to describe the PRO contract and to outline its major provisions.

Like Virgil's cyclopean monster, the entire contract is a daunting creature, consisting of many separate parts, "complex in its aspect and diverse in its ways." The three primary documents that form the nucleus of the contract are: 1) a brief outline of the work a PRO must perform, the so-called Scope of Work, fortysomething pages in all; 2) the successful bidder's Technical Proposal describing in detail how it will accomplish the required work; 3) the bidder's Business Proposal detailing the expected cost of performing that work and a proposed budget. (Note: The term of the contract is October 1, 1989, through September 30, 1992.)

Work To Be Performed

The PRO Scope of Work was mailed to all AFMC members last year. As noted above, AFMC's Technical Proposal as accepted by HCFA provides considerable detail in explaining how it will actually implement the work plan. It runs to about 150 pages, with another 175 pages of exhibits. In the case of inconsistencies between the Scope of Work and PRO's technical proposal, the Scope of Work takes precedence. Such inconsistencies may sometimes arise later from novel or unexpected interpretations of the Scope of Work.

Some of the major tasks required by the Scope of Work are listed below. This is a very condensed summary and far from complete.

A. *Review.* The type and number of reviews are specified in the Scope of Work and are programmed in the AFMC computer. The only changes are those mandated by contract modifications to the Scope of Work, and quarterly additions/deletions due to committee direction or intensification.

1. Reviews must be timely, i.e., completed within a specified number of days after receipt of the paid claim from the fiscal intermediary. No payment is made for untimely reviews.
2. For each case reviewed, the following review activities will be performed: application of generic quality screens; admission review; discharge review; invasive procedure review; DRG validation; coverage review; waiver of liability determination.
3. Some of the types of review or cases to be reviewed include (this is not a complete listing): random sample; transfers; re-admissions and intervening care; targeted DRGs; day and cost outliers; non-PPS facilities; ambulatory surgery; pre-admission/pre-procedure review; local objectives; reconsiderations.

B. *Quality Review Plan.* This is an elaborate and highly structured process, described at length in the Scope of Work, involving problem identification, severity levels, data profiling, weighted severity scores, and a schedule of interventions by the PRO. Briefly, when the PRO confirms a quality problem with a provider (physician or facility), it assigns numerical points depending on the severity of the problem; points are tallied quarterly and trigger "interventions" such as education, more review and, ultimately, possible sanction proceedings.

The quality review plan is an extremely prominent part of the current PRO contract from HCFA's perspective. J. David Busby, M.D., AFMC's medical director, has discussed it at many medical staff meetings across the state.

* Dr. Brasher is the Chief Executive Officer, Arkansas Foundation for Medical Care, Fort Smith, Arkansas.

C. *Beneficiary Relations.* The contract requires a PRO to perform considerable activities on behalf of Medicare beneficiaries, including the following: 1) hospitals may give patients "notices of noncoverage" advising that Medicare will not cover a particular admission or service and that the patient will be liable for charges. In most instances, the PRO must review these notices for appropriateness. 2) The PRO must conduct community outreach programs that inform and educate beneficiaries about the PRO program, the prospective payment system and their rights under Medicare. AFMC will hold some 20 such meetings around the state each year. 3) The PRO is required to review each beneficiary complaint concerning quality of care involving services reimbursable by Medicare.

D. *Physician/Provider Relations.* An "interaction plan" is required that details education programs for hospitals and physicians, including meetings, seminars, workshops, brochures, reports, and other forms of communications. Again, AFMC will hold about 20 regional meetings each year for this purpose, in addition to the annual statewide meeting. Further, the medical director regularly visits individual hospitals to speak with their medical and administrative staffs.

E. *Reporting.* As may be expected with a government contract, there are very extensive reporting requirements, including monthly, quarterly, semiannual and annual reports. The total amount of reports is enormous, the specifications alone running to 118 pages.

Budget

The AFMC proposal is in the neighborhood of 250 pages. The PRO budget must be developed and submitted in a format and according to specifications required by HCFA. Sometimes these involve accounting categories, originated by agencies like the Office of Management and Budget, which do not correspond to normal business cost centers. PROs are reimbursed for their work according to a schedule that includes fixed and variable rates. The fixed rate recognizes overhead and administrative costs that are relatively constant and not directly linked to volume of review, while the variable portion is supposed to reimburse direct review costs.

The three-year fixed portion of the budget is $8,244,745. This is disbursed in monthly payments of $229,020.

The variable portion is paid for required reviews completed each month, at the rate of $29.16 per complex review, $16.39 per simple review and $7.97 per ambulatory review. There are ceilings for each of these review types as well as an overall variable review cost ceiling of $3,505,255; AFMC projects substantially less than this. There is also a photocopying pass-through allowable of $309,669 to pay hospitals for copying and mailing records.

How is the contract money spent? About 55% is for salaries, 20% goes to physicians for review and 25% for operating costs. The Foundation has regular audits, which are available for inspection at our offices.

Champus

PROs also perform review for the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), Department of Defense. This program is piggybacked on the PRO contract and has its own Scope of Work (35 pages), Technical Proposal (114 pages) and Business Proposal (approx. 250 pages). There are many similarities with the Medicare review but also numerous differences. The Foundation's CHAMPUS review is funded at a fixed rate of $63,453 per annum.

Contract Administration

The following individuals are designated key personnel in the contract: Morton C. Wilson, M.D., chairman; J. David Busby, M.D., executive vice president for medical affairs; Russell G. Brasher, Ph.D., chief executive officer; Peggy S. McKinney, B.S.N., chief operating officer.

Contract modifications are generally initiated by HCFA central office in Baltimore. These occur for a variety of reasons, frequently due to new legislation in Congress. Day-to-day oversight is through the HCFA regional office in Dallas.

CERTs, REPs, and FARs

As is well known, an organization must satisfy a multitude of requirements to be a government contractor. In the PRO contract, AFMC makes signed "certifications and representations" that it will comply with certain federal regulations such as the Certificate of Independent Price Determination, Small Disadvantaged Business Concern Representation (SADBUS), Walsh-Healy Public Contracts Act Representation, Certification of Nonsegregated Facilities, Affirmative Action Compliance, Accessibility to Persons with Disabilities, Organizational Conflicts of Interest - and a host of others. The contract incorporates by reference approximately 70 additional federal acquisition regulations, FARs, which address concerns ranging from Cost Accounting Standards (52.230-03) to Convict Labor (52.222-03).

Although there remain substantial portions of the contract we have not touched upon, perhaps we have covered more than most readers really care to know. Many of the aspects of PRO review that physicians and hospitals encounter on a day-to-day basis are governed not by the contract but by the HCFA PRO Manual, which is a detailed procedure manual. Nevertheless, we hope that our brief excursion through this document has satisfied the curiosity of many readers and will assist them in understanding the activities of the Foundation.

Ten Commandments of Peer Review

1. Thou shalt not use vague language or personal references in describing review.
2. Thou shalt not use strong, irritative, or inflammatory words in review.
3. Thou shalt base all decisions upon facts available at time of care.
4. Thou shalt base no decisions solely upon outcome.
5. Thou shalt utilize dynamic community standards.
6. Thou shalt give benefit of doubt to the physician at the bedside.
7. Thou shalt recognize that medicine is not practiced as a perfect science.
8. Thou shalt match review to true peers whenever possible.
9. Thou shalt not review friends, enemies, or competitors.
10. Thou shalt not jump to a premature decision.

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Arkansas' Best Kept Medical Services Secret

Norton Wilson
Executive Director

Located mainly in small, rural areas, quietly delivering quality care to patients who pay only what they can afford, Community Health Centers of Arkansas is perhaps the states' best kept medical services secret.

Sharing in the secret, 60,000 Arkansans with 240,000 patient visits have received treatment at the 24 center locations.

Depending on family income and size, for as little as $5.00 to $25.00, Arkansans can be treated for almost any health problem. ***No one*** is turned away regardless of his or her ability to pay. Although centers are sometimes located in larger cities, such as Pine Bluff and East Little Rock, generally they are found in rural areas such as Clarendon, Redfield, Augusta, Wilmot, Bearden, Imboden, and Portland. In many counties, the centers are the only medical facilities available.

Center Missions

Community Health Centers were created because of the lack of adequate health care in underserved areas. The CHCs were intended by Congress to supplement and complement the existing health care system. The centers do not compete with the private sector, but work with private physicians, pharmacists, dentists, and local state health department clinics to provide a comprehensive approach to health needs.

Diagnostic, laboratory, and radiological services are provided along with such preventative measures as eye and ear exams, family planning, nutritional assessment, and immunizations. In addition, both pharmaceutical services and dental services are available. Transportation to and from the centers is available for handicapped, elderly, and others in need. Emergency and after hour care, health education, prenatal and well-child treatment services are also offered.

Medical Providers Needed

With all the excellent services the CHCs are equipped to provide, and with an ever-increasing number of people becoming aware of their existence, the centers are becoming caught in a two-way crunch resulting in a spiraling demand for practitioners.

First, numerous hospital closings during the past few years have created tremendous health-need pressures from communities that suddenly find themselves without access to medical help. Second, fewer and fewer new physicians are going into practice in rural Arkansas. This is unfortunate, but understandable: urban areas usually have more favorable living conditions and greater income potential than do rural areas. Fortunately, however, there are highly qualified doctors who do prefer the slower pace of rural life. This, in addition to a good guaranteed income, job satisfaction, all the usual benefits, plus ***time off***, is attracting many physicians who want not only a good job, but also a 40 hour work week norm and time to be with their families.

Perhaps, as the secret spreads, many Arkansans will be able to avail themselves of the benefits and services of the CHCs, and the physicians, dentists, and pediatricians will be there to meet their needs.

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Physician Controlled Drug Records

Don Phillips, P.D.*

Summary

A general understanding of the laws and regulations of the applicable standards of conduct in the use of controlled drugs will assist every physician in recognizing potential problems and dealing with them in an effective manner without the risk of disciplinary action. The investigators for the Arkansas State Medical Board routinely check controlled drug prescribing, ordering and prescribing habits by random periodic surveys throughout the state. Records that accurately reflect a diagnostic assessment of a medical condition and complete accountability for controlled drugs administered, dispensed or prescribed would substantially reduce the likelihood of excessive prescribing for other than legitimate medical purposes.

Records

Physicians are accountable for the type and quantity of controlled drugs they make available to their patients and such accountability requires accurate records.

Arkansas State Board of Health Rules and Regulations Pertaining to Controlled Drugs require every physician to keep a record of such controlled drugs received, administered, dispensed or professionally used otherwise than by prescription.

Controlled drug records shall be maintained either separately from all other records or in such a form that the information required is readily retrievable from ordinary business records or patients records.

Adequate accountability does not require the use of a specific system or form, however, the system employed must be designed so that all requirements listed above are met.

It is important that every physician who utilizes controlled drugs in his practice recognize and follow the laws, rules and regulations which govern their use, use good clinical judgement and sound medical practices, keep accurate and complete records, and recognize the deceptive practices that drug abusers use to obtain drugs for illegal use.

Patient Records

The existence of an accurate record of treatment of a patient is crucial to the establishment of a legitimate medical purpose. If the absence of a medical record gives rise to an inference that there may not be a physician-patient relationship, then existence of an inaccurate or incomplete medical record most certainly gives rise to an inference that controlled drugs given to the patient were given in amounts not reasonably related to the proper medical management of the patient's illness.

The existence of a valid physician-patient relationship is crucial to the determination of whether treatment is offered for a "legitimate medical purpose", such a record should contain an appropriate history, physical examination and diagnostic tests, and the initiation of appropriate treatment. The absence of such evidence will, in many circumstances, lead to the conclusion that there is no valid physician-patient relationship and that the provision of controlled drugs by the physician to the individual was for reasons other than the legitimate treatment of a medical condition.

Office Staff Policy

On occasion, physicians are unknowingly jeopardized by actions of their office staff. This is especially true in instances when office procedure is unclear, or when staff is not fully aware of legal and ethical implications of improper prescribing practice, also there are those situations where staff members seek to take deliberate advantage of their situation.

To address this issue, the physician should assess the staffs awareness as they process your telephone calls from patients or pharmacists regarding your prescription for controlled drugs and refill authorization.

Is it your policy to allow office staff to authorize prescription refills for controlled drugs? Are refill authorizations noted on patients charts each time they are given? If records of refill authorization of controlled drug prescriptions are not kept, it is difficult for the physician to determine the abuse potential. One of the more frequently heard statements by physicians who are confronted with the magnitude of their prescribing is, "I had no idea I had prescribed so many controlled drugs for this patient."

For a copy of ***Rules and Regulations of the Arkansas State Board of Health Pertaining to Controlled Drugs***, write to: Division of Pharmacy Services and Drug Control, Arkansas Department of Health, 4815 W. Markham Street, Little Rock, Arkansas 72205-3867.

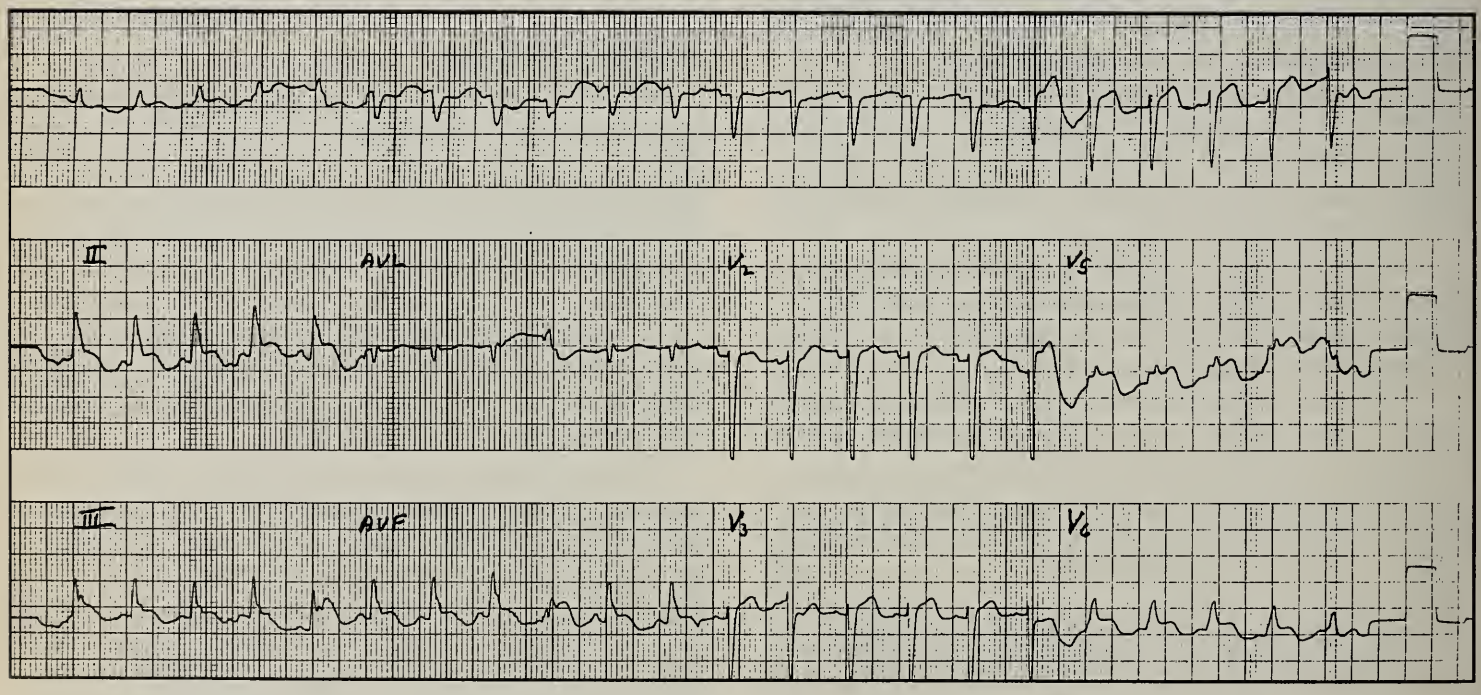
* Mr. Phillips is Director, Division of Pharmacy Services and Drug Control, of the Arkansas Department of Health, Little Rock, Arkansas.

ELECTROCARDIOGRAM of the MONTH

William C. Furlow, M.D.
John W. Watson, M.D.
Division of Cardiology
UAMS, Little Rock, Arkansas

CLINICAL HISTORY:

P.N. is a 65-year-old woman who presented to the hospital because of crushing substernal chest pain of two hours duration which was associated with intense diaphoresis. Her past history was positive for strokes and hypertension. Her cardiovascular examination revealed hypertension, pulmonary crackles, an S3 gallop, and a murmur of mitral regurgitation. What do you think of her electrocardiogram?



DISCUSSION:

Sinus rhythm is noted. Classic changes are present for left atrial and left ventricular hypertrophy. The trace suggests the presence of past inferior and septal infarctions. Old electrocardiograms as well as sequential traces would be of great value for evident reasons.

The editor wishes to thank Dr. Furlow, who practices internal medicine and cardiology in Conway, Arkansas, for his assistance with this month's featured electrocardiogram.

Things To Come

May 16-19

The National Conference of Physician Executives. Sponsored by the American College of Physician Executives, Tampa, FL. Marriott Rivercenter, San Antonio, TX. CME credit available. For more information, call 1 (800) 562-8088.

May 19

Trauma Symposium. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington,KY. For further information contact Susan Gilson at (606) 233-5161.

May 20-26

21st Family Medicine Review - Session II. Presented and sponsored by the University of Kentucky College of Medicine. Hyatt Regency Hotel, Lexington, KY. For further information contact Susan Gilson at (606) 233-5161.

May 25-27

Advances in Pediatrics. Presented by Catherine DeAngelis, M.D. (Ambulatory Pediatrics); Burton W. Fink, M.D. (Cardiology); Mark Sperling, M.D. (Endocrinology); Georges Peter, M.D. (Infectious Diseases); John E. Lewy, M.D. (Nephrology); Charles F. Weiss, M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Hilton Head Island, South Carolina. Sixteen Category I credit hours. Fees: $220, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016 and ask for CME Registration.

June 1-2

3rd Annual Contact Lens Course. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 6-9

Facial Rejuvenation. Sponsored by the Washington University School of Medicine, St. Louis, MO. Ritz-Carlton St. Louis Hotel. CME credit available. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 6-10

7th Annual Meeting of the Southern Orthopaedic Association. Sponsored by the Southern Orthopaedic Association, Birmingham, AL. Hyatt Regency Hotel, Maui, Hawaii. Category I CME credits available. For further information, contact Kathy McLendon at 1 (800) 423-4992.

June 7-9

Frontiers in Endosurgery: Flexible Endoscopy, Laser Surgery and Endourological Techniques. Sponsored by the Washington University School of Medicine, St. Louis, MO. CME credit available. FOR UROLOGISTS ONLY. For further information, contact Cathy Caruso at 1 (800) 325-9862.

June 11-15

Physician in Management I & II. Sponsored by the American College for Physician Executives, Tampa, FL. Four Seasons Hotel, Philadelphia, PA. CME credit available. For more information, call 1 (800) 562-8088.

June 21-25

The AMA Hospital Medical Staff Section 15th Assembly Meeting. Sponsored by the American Medical Association. Chicago Marriott Hotel in Chicago, IL. For further information, contact the AMA at (312) 645-5000.

June 22-24

Clinical Pediatrics. Presented by Richard J. Summers, M.D. (Allergy); Barton D. Schmitt, M.D. (Behavioral Pediatrics); Sidney Hurwitz, M.D. (Dermatology); William F. Balistreri, M.D. (Gastroenterology); Ellen R. Wald, M.D. (Infectious Diseases); R. James McKay Jr., M.D. (Course Monitor). Sponsored by the American Academy of Pediatrics. Washington, D.C. Fees: $200, AAP Resident Fellow or allied health professional; $300, AAP Fellow; $365, nonmember. For further information call 1 (800) 433-9016.

June 23-26

Summer Executive Symposium. Sponsored by the American College of Physician Executives, Tampa, FL. LeQuatre Saisons, Montreal, Quebec, Canada. CME credit available. For more information, call 1 (800) 562-8088.

July 22-27

Physicians and Their Families. Sponsored by the Menninger Clinic, Topeka, KS. Grand Butte Hotel, Crested Butte, CO. Twenty-three hours of Category I credit hours. Fees: $750. For further information, call Jayne Roberts at 1 (800) 228-7377, ext. 5994.

August 6-10

Physicians in Management I&II. Sponsored by the American College of Physician Executives, Tampa, FL. Four Seasons Hotel, Toronto, Ontario, Canada. CME credit available. For more information, call 1 (800) 562-8088.

August 8-12

3rd Annual Meeting of the Southern Association for Oncology. Sponsored by the Southern Medical Association and the Southern Association for Oncology. Orlando, FL. Fees: $400 SAO members; $505 Non-members. Category I credit available. For more information, call 1 (800) 423-4992.

Keeping Up

Epilepsy: Diagnosis and Treatment

May 25, 8:30 a.m. - 4:00 p.m. Presented by the Arkansas Children's Hospital. Sponsored by Abbott Laboratories, Ciba-Geigy, and Parke-Davis Laboratories. Arkansas Children's Hospital Auditorium, Little Rock. Six Category I credit hours. Fee: $25.00.

Loss Prevention Seminar

June 2, 8:00 a.m. - 11:00 a.m. and 12:00 noon - 3:00 p.m. Presented by State Volunteer Mutual Insurance Company and co-sponsored by the Arkansas Medical Society. Best Western InnTowne, Little Rock. Two Category I credit hours. Free admission. For more information, call 1 (800) 633-3215 or (615) 377-1999.

Critical Care Program

May 30, 31, June 1, 4, 5. Presented by St. Vincent Infirmary Medical Center. Fee: $75.00. For more information, call Sandy DeSalvo at (501) 660-3685.

Pediatric Advanced Life Support Provider Course

June 2, 3. Presented by St. Vincent Infirmary Medical Center. Center for Health Education, St. Vincent. Fee: $100.00; no charge for St. Vincent employees. For more information, call Betty Diehl at (501) 660-3683.

Adult Diabetes Mellitus: Basic Concepts in Management

May 24, 31, June 7. Presented by St. Vincent Infirmary Medical Center. Robert Sakon Classroom or Conference Center #1. Fee: $125.00; $100.00 per person for groups of three or more; no charge to St. Vincent employees. For more information, call Claude Whitcomb (501) 660-3673.

Basic Medical Terminology

May 23,30. Presented by St. Vincent Infirmary Medical Center. For more information, call Fran Scheuing at (501) 660-3672. Fee: $31.95.

Basic Dysrhythmia Course

June 4, 6, 8, 11, 13. Presented by St. Vincent Infirmary Medical Center. Center for Health Education, St. Vincent. Fee: $100 per person, $7.50 textbook fee, $6.50 calipers. For more information, call Marcia Justice at (501) 660-3678.

NLN/ANR Review Course

June 7, 8, 11, 12, 13. Presented by St. Vincent Infirmary Medical Center. South Auditorium, St. Vincent. Fee: $175.00 per person; $150.00 members of NSNA. For more information, call (501) 660-3683.

Recurring Education Programs

As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.

FAYETTEVILLE - VA MEDICAL CENTER

Medical Conference (varying topics), third Wednesday, 12:30 p.m., Conference Room, Building 1, VAMC
Mortality/Morbidity Conference, fourth Wednesday, 2:45 p.m., Conference Room, Building 1, VAMC

HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER

Continuing Medical Education Luncheon, varying topics, May 11 and May 25, 12:30 p.m., Ozark/Quapaw Room, AMI National Park Medical Center, One Category I credit per meeting

LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Building, Room 457
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Building, Auditorium
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER

CARTI Tumor Conference, first Wednesday, 12:00 noon, CARTI Auditorium. Lunch is served.
Cancer Conference, third Thursday, 12:00 noon, Laboratory Conference Room. Lunch is provided.
Hematology-Oncology Conference, second Thursday, 12:00 noon, Laboratory Library. Sandwich buffet served.
Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla Room. Refreshments are provided.
General Medicine Journal Club, Tuesdays, 12:00 noon, Conference Room 1. Lunch is provided.
Pulmonary Conference, second and fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla Room. Sandwich buffet is served.
Surgery Journal Club, Mondays, 12:00 noon, Operating Room Conference Room (2 Northwest). Sandwich buffet served.
Interdisciplinary AIDS Conferernce, second Friday, 12:00 noon, LaHarpe Room. Sandwich buffet is served.
Peripheral Vascular Disease Conference, first Tuesday, 5:30 p.m., Conference Room 1. Refreshments are provided.
GYN/Oncology Conference, second Monday, 12:00 noon, location to be announced. Lunch provided.

LITTLE ROCK-BAPTIST MEDICAL CENTER

Anesthesiology Conference, third Thursday, 7:00 a.m., Conference Room 1
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lectures and case presentations. A light lunch is provided.
Pathology Conference, third Tuesday, 3:00 p.m., Pathology Library
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. A light lunch is provided.

As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.

LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

ACRC/CARTI Tumor Conference, Wednesdays, 12:00 noon, CARTI Auditorium, Markham & University
ACRC Oncology Forum, fourth Thursday, 4:00 p.m., UAMS ACRC 2nd Floor Conference Room, 1.5 credits
Anesthesia Conference Series, Wednesdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
Anesthesia Morbidity and Mortality Conference, second and fourth Tuesdays, 6:45 a.m.; first, third and fifth Thursdays, 4:00 p.m., UAMS Education Building, Room G/110 A&B
CARTI North Tumor Board Cancer Conference, second Wednesday, 12:00 noon, CARTI North, Searcy
Child Psychiatry Clinical Case Conference, first Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Child Psychiatry Research Review, fourth Friday, 1:00 p.m., Arkansas Children's Hospital, Child Study Center Conference Room H5727
Dermatopathology Conference, Tuesdays, 8:00 a.m., UAMS Education Building, Room G/108 A&B
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Building, Room G/110A&B
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Building, Room G/110A&B
Emergency Medicine Grand Rounds 1, third Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Grand Rounds 2, third Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Morbidity and Mortality Conference, fourth Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Radiology Conference, fourth Tuesday, 3:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Conference, first Tuesday, 4:00 p.m., UAMS Education Building, Room B/106A&B
Emergency Medicine Toxicology Rounds, first Tuesdays 3:00 p.m., UAMS Education Building, Room B/106A&B
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology Conference Room, #M1/293.
Interdisciplinary Gynecologic Cancer Conference, Fridays, 12:30 p.m., UAMS Education Building, Room G106 A&B
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Building, Rom G/131A&B
Medicine Research Conference, three Wednesdays per month, 4:30 p.m. Shorey Building, Room 3S06
Neurology Clinical Case Conference, Thursdays, 8:00 a.m. Rotates between UAMS (7D33) and LRVAMC (3S) and ACH

Neuropathology Conference, Thursdays, 10:00 p.m. UAMS Autopsy Room
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33
Ob/Gyn Grand Rounds, Wednesdays, 8:00 a.m., UAMS Education Building, Room G/131B
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, Room 3/150, 2 credit hours
Orthopaedic Basic Science Conference, occasional Tuesdays, 11:00 a.m., UAMS Education Bldg., Room B/135
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Building, Room B/135, 1.5 credit hours
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Building, Room B/135
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Building, Room B/135
Pathology Autopsy Conference, Mondays, 9:05 a.m., LRVAMC Morgue
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium
St. Vincent Urology Grand Rounds, first Tuesday, 5:30 p.m., St. Vincent Infirmary, Education Building, Room 159
Surgery Basic Sciences Conference, first Wednesday, 4:00 p.m., UAMS Education Building, Room G/141
Surgery Morbidity and Mortality Conference, Wednesdays, 7:00 a.m., UAMS Education Building, Room G/141A
Surgery Staff/Clinical Case Conference, alternating Tuesdays, 7:00 a.m., UAMS Education Building, Room G/141/
Surgery Review Conference, every second, third and fourth Wednesday, 4:00 p.m., UAMS Education Building, Rom G/141
Urology Basic Sciences Conference, second Tuesday, 5:00 p.m., UAMS Education Building, Room G/106A&B
Urology Clinical Didactic Conference, third Tuesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Core Conference, once or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Grand Rounds, second and fourth Tuesday, 5:00 p.m., VAMC-LR (4D)
*Urology Morbidity and Mortality Conferenc*e, last Wednesday, 5:00 p.m., UAMS Urology Office, Room 2S08
Urology Teaching Conference, one or twice monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
Uro-Radiology Workshop (Urologic Imaging), once monthly, 5:00 p.m., UAMS Urology Office, Room 2S08
VA Chest Conference (combined Surgical/Medical Chest Conference), alternating Mondays, 12:15 p.m., VAMC-LR, Room 2D109
VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine Conference Room, Room 1D173
VA Hematopathology Conference, Wednesdays, 3:00 p.m., LRVAMC Conference Room
VA Lung Cancer Conference (combined Medical/Surgical Lung Cancer Conference), Tuesdays, 3:00 p.m., LRVA, Room 2E142
VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Building 68
VA Physical Medicine and Rehab Grand Rounds, fourth Friday, 11:00 a.m., VAMC-NLR Building 68, Room 118 or Arkansas Rehab Institute
VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, Room 2D109, 1.25 credit hours
VA Topics in Rehabilitation Medicine, Thursdays, 8:00 a.m., VAMC-NLR Building 68, Room 118
VA Weekly Tumor Conference, Tuesdays, 4:00 p.m., VAMC-LR, Pathology Conference Room
Vascular/Radiology Conference, Thursdays, 7:00 a.m., LRVAMC Radiology Conference Room
Vascular Teaching Conference, Thursdays, 8:00 a.m., LRVAMC Radiology Conference Room.

EL DORADO - AHEC

Behavioral Sciences Conference, first and fourth Friday, 12:30 p.m., AHEC - South Arkansas.
Chest Conference, third Wednesday, 12:30 p.m., Warner Brown Hospital
Gynecology-Pathology Conference, second Friday, 12:30 p.m., AHEC-South Arkansas
Internal Medicine Conference, first, second and fourth Wednesday, 12:30 p.m., AHEC-South Arkansas
Pathology Conference, second Tuesday, 12:15 p.m., AHEC-South Arkansas
Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas
Obstetrics-Gynecology Conference, fourth Thursday, 12:30 p.m., AHEC-South Arkansas
Surgical Conference, first, second and third Monday, 12:30 p.m., AHEC-South Arkansas
Tumor Clinic, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

FAYETTEVILLE - AHEC NORTHWEST

Cardiology Lecture Series, first Monday, 1:00 p.m., Washington Regional Medical Center
City Hospital Staff Meetings, second Friday, 12:00 noon, Fayetteville City Hospital
Family Medicine Conference, each Tuesday and Wednesday, AHEC - NW, 241 W. Spring, Fayetteville
Internal Medicine Conference, each Tuesday, 12:00 noon, Washington Regional Medical Center

FORT SMITH - AHEC

Internal Medicine, first Tuesday, 12:30 p.m., Medical Library, Sparks Regional Medical Center

JONESBORO-AHEC NORTHEAST

AHEC Lecture Series, first and third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.
Arkansas Methodist Hospital CME Conference, May 11, 15, 25; June 8 and 22, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.
Cherokee Village CME Conference, May 16; June 13, 12:00 noon, Baptist Memorial Hospital Cafeteria, Cherokee Village
Chest Conference, second Tuesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided

Cleburne County Medical Society, second Thursday, 12:00 noon, Cleburne Memorial Hospital - Herbert L. Thomas Conference Room, Heber Springs
Eaker AFB CME Conference, second and third Wednesday, 12:00 noon or 4:00 p.m., Hospital Cafeteria
Independence County Medical Society, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville
Interesting Case Conference, fourth and fifth Tuesday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Jackson County Medical Society, third Thursday, 7:00 p.m., Newport Country Club, Newport
Kennett CME Conference, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO
Methodist Hospital of Jonesboro CME Conference, second Tuesday, 7:30 p.m., Cafeteria, Methodist Hospital of Jonesboro
Neurological-Neurosurgical Conference, first Monday, 12:00 noon, St. Bernard's Dietary Conference Room
Neuroradiology Conference, third Friday, 12:00 noon, St. Bernards Dietary Conference Room. Lunch provided.
Perinatal Conference, second Wednesday, 12:00 noon, St. Bernard's Dietary Conference Room. Lunch provided.
Pocahontas CME Conference, third Wednesday, 12:00 noon and 7:30 p.m., Randolph County Medical Center Boardroom
Walnut Ridge CME Conference, third and last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria
West Plains CME Conference, fourth Wednesday, 6:30 p.m., West Plains Country Club, West Plains, MO
White River Medical Center CME Conference, May 18 & 24; June 21, 12:00 noon, Hospital Boardroom

PINE BLUFF-AHEC

Behavioral Science Conference, first and third Thursday, 12:00 noon, Jefferson Regional Medical Center
Chest Conference, second and fourth Friday, 12:00 noon, Jefferson Regional Medical Center
Family Practice Conference, first and fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center
Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center
Internal Medicine Conference, second and fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center
Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center
Orthopedic Case Conference, second and fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.
Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center
Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center
Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.
Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center
Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

TEXARKANA-AHEC SOUTHWEST

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.
Cine Radiology, second Friday, 12:00 noon, Wadley Regional Medical Center.
Echo-Cardiology, fourth Friday, 12:00 noon, Wadley Regional Medical Center
Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital and Wadley Regional Medical Center
Neuro-Radiology Conference, first and third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center
Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital
AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

Family Physician - Fifth FP sought to join progressive 20 man multi-specialty group in historic Midwest community. Fully equipped 120 bed hospital with plans for new facility, excellent school system, many recreational and civic activities. competitive starting salary and benefits package with productivity, bonus and partnership potential. Full range of sub-specialists available. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

Internist - Third internist to join very busy progressive 20 man multi-specialty group in historic Midwest community. Fully equipped 120 bed hospital with plans for new facility, excellent school system, many recreational and civic activities. Competitive starting salary and benefits package with productivity bonus and partnership potential. Call Cheryl Broderick, E.G. Todd Associates, (800) 762-9213 or collect (508) 688-9063.

Medicine in the News

AMS Auxiliary DWI Awareness Contest

Mrs. J. Larry Lawson, president of the AMS Auxiliary, and Mrs. Ray Jouett, chairman of the Auxiliary's DWI Committee, announced Harding University as the winner of Phase I of its DWI Awareness Contest held during the first semester of 1989, and presented the $1,000 to Dr. Lou Butterfield, chairman of the Department of Communications. The presentation was made in the Governor's Conference Room at the State Capitol, at which time the kick-off for Phase II of the program was held. Phase I of the DWI Awareness Program targets college students and Phase II targets high school students.

Joining the Auxiliary in this project are the Arkansas Medical Society, the Arkansas Automobile Dealers' Association, the Division of Drug and Alcohol Abuse Prevention, and the Arkansas Chapter, American College of Emergency Physicians.



Nikki Lawson and Sara Jouett are pictured with the winning students of Harding College and their professor, Dr. Lou Butterfield.

Health Care Access Foundation

As of March 1990, the Arkansas Health Care Access Foundation has provided free medical services to 1,137 medically indigent persons.

The program has 1,464 volunteer health care providers including medical doctors, home health agencies, and pharmacists. These providers have rendered free treatment in 66 of the 75 counties.

AMA Projections on Cancer

The American Cancer Society is making projections again.

And it's estimated that 11,300 new cases of cancer will occur in Arkansas in 1990. That's a death rate of 165 per 100,000 - which falls below the national average of 171 deaths per 100,000.

Arkansas is, however, about middle if the states are placed in rank order. About half of the states have higher death rates, half lower. And here, the most lives will be lost because of lung cancer - followed by colon and rectal cancer and female breast cancer.

Hospital Mortality Rates

The Health Care Financing Administration's (HCFA) third annual report on Medicare hospital patient death rates shows that 196 U.S. hospitals exceeded overall predicted rates in 1988 compared with 194 in 1987. that's only 3.4% of the 5,763 hospitals surveyed.

In Arkansas, 13 of the 90 hospitals studied by HCFA exceeded their overall predicted mortality rates, giving us a much higher percentage (14.4%) of such hospitals than found nationwide.

Two Arkansas hospitals were among 33 nationwide that exceeded the predicted ranges for three consecutive years. No Arkansas hospital ranked below its anticipated death rate, although several had mortality rates less than half the number predicted.

A review of the comments HCFA received from Arkansas hospitals reveals a consensus of opinion that the Arkansas mortality rates are not a meaningful measure of quality and will continue to be high as long as patients admitted to the hospital are older and sicker than normal. A high volume of such patients should be expected in Arkansas which is led only by Florida in the number of elderly persons per 1,000 population.

Doctors Love the Work, Hate the Business

One in five physicians recently surveyed by Physician's Management magazine stated that they wished they had picked a profession other than medicine. Perhaps more revealing is that two-thirds of physicians would not recommend a medical career to their children. The Cleveland-based magazine reported survey results in its January 1990 issue.

The aspects of medicine the respondents considered the most offensive included the paperwork generated by third-party payers, the increasing threat of litigation, the reduced financial reward, professional politics, managing a practice, and dealing with minor patient complaints.

The respondents seem to indicate physicians would be willing to accept longer hours, reduced income, and even the paperwork, if they could retain the freedom to decide how and when care should be provided. But, they are

finding that freedom is being eroded by third-party payers, bureaucracies, lawyers, and regulatory agencies.

The result, according to respondents, is a negative impact on patient care.

Medicare Physician Payment Reform ETs vs. MVPS

The Medicare volume performance standard (MVPS), recently passed by Congress, is not an expenditure target (ET). The ET concept adopted by the House Ways and Means Committee, while labelled as a target, would have resulted in a narrow formula designed to automatically mandate annual reductions in the amount paid for medical services under Medicare. By contrast, the MVPS is first and foremost a mechanism to monitor and understand the underlying basis for changes in the volume of Medicare physician services.

Operation Focus

In a recent Gallup poll concerning Americans' attitudes towards the current costs, quality, and availability of medical care in the United States, a majority of those surveyed say that AIDS is the number-one health threat to Americans and that cost of medical care is the second greatest threat.

The Gallup Organization found that nearly three-fourths of the respondents said they either strongly favored or favored the U.S. adoption of a national health-care system "that would provide health care to all citizens".

Americans gave low marks to the federal government's role in regulating health care. "Among factors relating to a health-care system, freedom of choice is most influential, followed by waiting time and distance traveled. Secondly, the data indicates that support of a national health-care delivery system is delicately balanced and that support for the system is greatly eroded", Gallup reports.

Respondents also favored increased government spending on health care. They said that they would support additional insurance coverage for older Americans with the federal government bearing the financial responsibility.

Americans have particularly strong feelings about access to quality care and freedom of choice of physicians. They outdistanced cost as an influential factor.

The Gallup survey was sponsored by OPERATION FOCUS, an educational effort comprised of concerned citizens, business and civic leaders and representatives of the medical profession.

AMA Joins Project To Improve Health

The American Medical Association, the RAND Corporation, and the newly established Academic Medical Center Consortium (AMCC) have established "The Clinical Appropriateness Initiative," a cooperative project to identify and promote appropriate health care and reduce inappropriate health care.

The three organizations signed an agreement to establish a partnership between the research and medical practice community to improve the health of the American people.

The project plan consists of ten major activities. The AMCC and RAND will conduct research on and develop appropriateness criteria for selected medical and surgical procedures, diagnoses and conditions. The AMS, through collaboration with the national medical specialty societies and state and local medical societies, will facilitate development of patient management strategies, known as practice parameters, based on the appropriateness criteria. After initial development, the AMA will disseminate the practice parameters and facilitate their updating by the national medical specialty societies. The AMCC, RAND, and the AMA will evaluate the effectiveness of the initiative in identifying and promoting appropriate care and reducing inappropriate care.

Studies on four procedures are underway: cataract surgery; aortic aneurysm surgery; carotid endarterectomy; and coronary artery bypass surgery. Procedures under consideration for future criteria development include: coronary angioplasty, abdominal ultrasound, cholecystectomy, lower extremity bypass graft, electrocardiography, hip replacement, prostatectomy, and laminectomy.

The AMA, in conjunction with the national medical specialty societies and other physician organizations, will use the appropriateness criteria, research findings, an clinical experience to develop practice parameters that are scientifically sound, clinically relevant, and applicable in the daily practice of medicine. The practice parameters can also be used as the foundation for quality assurance programs, utilization review systems and insurance coverage policies.

Winona, MS. - Family Practice, Surgery, Internal Medicine, OB/GYN, Pediatrics. Excellent quality of life, exceptional public school system. Sumner Scholarship Grant for college tuition. Crossroads of I-55 and Highway 82, 88 miles to Jackson, 110 to Memphis. Recruitment package available. Contact Richard Manning, Administrator, Tyler Holmes Memorial Hospital, Tyler Holmes Drive, Winona, MS 38967, (601) 283-4114.

AMS NewsMakers

James S. Adamson, M.D., a pulmonologist in Little Rock, has been named chief of staff at Baptist Medical Center.

Robert Dickins, M.D., a neurosurgeon in Little Rock, has been named vice chief of staff at Baptist Medical Center.

Bruce Glover, M.D., of Fort Smith, has been named vice chief of staff of Sparks Regional Medical Center in Fort Smith.

R. Jerry Mann, M.D., of Little Rock, has been appointed chairman of the Commission on Public Health and Scientific Affairs of the American Academy of Family Physicians.

Dana Rabideau, M.D., of Fort Smith, has been named chief of medical staff of Sparks Regional Medical Center in Fort Smith.

S. William Ross, M.D., of Little Rock, was honored recently for his long years of service to St. Vincent Infirmary Medical Center. Dr. Ross was instrumental in getting the number of acute-care beds increased and promoted nursing education programs.

Peter Thomas, M.D., of Little Rock, was honored by co-workers, on his 75th birthday, for his 45 years of medical service. Dr. Thomas is director of medical affairs with Southwest Hospital in Little Rock.

William D. White, M.D., of Searcy, has been appointed associate medical director for Arkansas Blue Cross and Blue Shield. Dr. White is an assistant clinical professor of medicine at UAMS.

New Members

BENTON COUNTY

Cox, Thomas E., Anesthesiology, Rogers. Born January 22, 1959, Little Rock. Pre-medical education, Johns Hopkins University, 1981. Medical education, University of Virginia, Charlottesville, VA, 1985. Internship, Good Samaritan/Phoenix VA Medical Center, 1986. Residency, Oregon Health Sciences University, 1989. Practice experience, 8 months. Pending certification. Member, American Society of Anesthesiologists, International Society of Anesthesiologists.

Wilkerson, Danny, Anesthesiology, Rogers. Born August 2, 1955, Rogers. Pre-medical education, University of Arkansas, Fayetteville, 1976. Medical education, UAMS, Little Rock, 1983. Internship/residency, UAMS. Practice experience, 3 1/2 years. Board eligible.

CARROLL COUNTY

Martinson, Alice M., Orthopaedics, Berryville. Born January 28, 1944, Philadelphia, PA. Pre-medical/medical education, George Washington University, Washington, D.C., 1967. Internship/residency, Naval Hospital, San Diego, CA, 1972. Military, U.S. Navy, 1966-1989. Practice experience, 18 years. Board certified. Member, American Academy of Orthopaedic Surgeons.

COLUMBIA COUNTY

Hawley, James W. Jr., Family Practice, Magnolia. Born September 6, 1953, Camden. Pre-medical education, Ouachita Baptist University, Arkadelphia, 1975; Southern Arkansas University, Magnolia, 1978. Medical education, UAMS, 1988. Internship, AHEC South Arkansas, El Dorado, 1989.

CRAIGHEAD/POINSETT COUNTY

Cranfill, Ben J., Urology, Jonesboro. Born November 13, 1957, Friona, TX. Pre-medical education, Texas A&M University, 1979. Medical education, University of Texas Health Science Center, San Antonio, TX, 1983. Internship/residency, UAMS, 1988. Practice experience, 9 months. Member, American Medical Society, Arkansas Urologic Society.

GARLAND COUNTY

Pellegrino, Richard G., Neurology, Hot Springs. Born September 19, 1955, Bronx, NY. Pre-medical education, Manhattan College, 1976. Medical education, Albert Einstein College of Medicine, Bronx, NY, 1984. Internship, Westchester County Medical Center, 1985. Residency, Columbia Presbyterian Hospital, 1986; Hershey Medical Center, 1989. Member, American Academy of Neurology.

Russell, Mark S., Radiology, Hot Springs. Born December 8, 1952, Gainsville, FL. Pre-medical education, Western Kentucky University, 1977. Medical education, UAMS, 1985. Residency, University of Arkansas Medical Center, 1989. Board certified.

Stough, Dowling B., Dermatologic Plastic Surgery, Hot Springs. Born June 28, 1957, Birmingham, AL. Pre-medical education, U of A, Fayetteville, 1979. Medical education, UAMS. Internship, Baptist Memorial Hospital, 1985. Residency, UAMS, 1986. Practice experience, 2 years. Board certified. Member, American Academy of Cosmetic Surgery, American Academy of Dermatology.

JEFFERSON COUNTY

Pierce, Ried G., OB-G, Pine Bluff. Born February 29, 1956, Little Rock. Pre-medical education, University of Arkansas, 1978. Medical education, Tulane, New Orleans, LA, 1982. Internship/residency, University of Virginia, 1986. Practice experience, 3 1/2 years. Board certified. Appointments, Clinical Professor, U of A. Member, American Fertility Society, Gynecologic Laparoscopists.

MILLER COUNTY

Collins, Stanley R., Internal Medicine, Texarkana. Born June 3, 1950, Texarkana, AR. Pre-medical education, Hendrix College, Conway, 1972. Medical education, UAMS, Little Rock, 1986. Internship/residency, UAMS, 1989.

Dobbs, Michael E., Obstetrics/Gynecology, Texarkana. Born October 11, 1949, Tachikowa, Japan. Pre-medical education, Trinity University, San Antonio, TX, 1971. Medical education, University of Texas Medical Branch, Galveston, TX, 1975. Internship/residency, David Grant USAF Medial Center, Travis AFB, California, 1979. Military, USAF, 1971-1984. Practice experience, 10 years. Member, American College of Obstetrics and Gynecologists.

Fisher, John D., Diagnostic Radiology, Texarkana, TX. Born September 29, 1948, Little Rock. Pre-medical education, UALR, 1971. Medical education, UAMS, 1975. Internship, UAMS, 1976. Residency, University of Oklahoma Health Sciences Center, 1979. Practice experience, 10 years. Board certified.

Gabbie, Mark O., Family Practice, Texarkana, TX. Born February 14, 1960, Monticello. Pre-medical education, U of A, Fayetteville, 1982. Medical education, UAMS, 1986. Internship/residency, Jefferson Regional Medical Center, Pine Bluff, 1989. Practice experience, 3 years. Board eligible.

Payne, Alvin D., Internal Medicine, Texarkana, AR. Born October, 12, 1959, Dallas, TX. Pre-medical education, Austin College, 1982. Medical education, University of Texas Medical Branch, Galveston, TX, 1986. Internship/residency, Scott & White Hospital, Temple, TX, 1989. Pending certification.

Schmidt, Howard R., General Surgery, Texarkana, TX. Born July 26, 1958, Port Huron, MI. Pre-medical education, University of Mississippi, Jackson, 1980. Medical education, University of Mississippi, 1984. Internship/residency, UMC, 1989. Board eligible.

PULASKI COUNTY

Cavin, Lillian D., Radiology, Little Rock. Born July 31, 1956. Pre-medical education, Clemson University, 1978. Medical education, Medical University of South Carolina. Internship/residency, UAMS, 1987. Practice experience, 4 years. Board certified.

Granger, William T. III, Psychiatry, Little Rock. Born January 1, 1942, Pottsville, PA. Pre-medical education, American River, Sacramento, 1962; University of Arizona, Tucson, 1965. Medical education, UAMS, 1976. Internship/residency, UAMS, 1979. Military, USAF, 1962-present. Appointments, Assistant Clinical Professor, UAMS. Practice experience, 10 years. Board certified. Member, American Medical Association, American Psychiatric Association, Arkansas State Psychiatric.

Sinor, Elicia A., Emergency Medicine, Little Rock. Born August 12, 1960, Roanoke, VA. Pre-medical education, U of A, Fayetteville, 1982. Medical education, UAMS, 1986. Internship/residency, UAMS, 1989. Appointments, Instructor, UAMS.

SEBASTIAN COUNTY

Hendrickson, Jon R., General Pediatrics, Fort Smith. Born January 22, 1951, Kansas City, MO. Pre-medical education, University of Kansas, 1973. Medical education, University of Kansas, 1976. Residency, Childrens Mercy Hospital, Kansas City, MO. Board certified. Practice experience, 9 years. Member, American Academy of Pediatrics.

TRI-COUNTY

Pembrook, Richard, Cardiology, Fairfield Bay. Born May 12, 1930, Lincoln, NE. Pre-medical education, University of Minnesota, 1957. Medical education, University of Minnesota, 1963. Internship, USPHS Hospital, Baltimore, MD, 1964. Residency, University of New Mexico Hospital, Albuquerque, NM, 1967; Maine Medical Center, Portland, MN, 1972. Military, US Navy,

1951-54. Practice experience, 26 years. Board certified. Member, Fellow of the American College of Physicians, Fellow ofthe Council of Clinical Cardiology of the American Heart Association.

UNION COUNTY

Kay, Larry L., Diagnositc Radiology, El Dorado. Born, November 4, 1943, Vinita, OK. Pre-medical education, Oklahoma State University, 1965. Medical education, University of Oklahoma School of Medicine, Oklahoma City, 1969. Internship, St. Lukes Hospital, Kansas City, MO, 1970. Residency, University of Texas Medical Branch, Galveston, TX, 1977. Military, US Navy, 1970-74. Practice experience, 12 years. Board certified. Member, Texas Radiology Society, Radiology Society of North America, American College of Radiology.

WASHINGTON COUNTY

Cooper, Craig C., Family Practice, Springdale. Born, October 30, 1943, Hartley, IO. Pre-medical education, Iowa State Unversity 1965; University of Wisconsin, 1970. Medical education, Oklahoma State University, 1986. Internship, Phoenix General Hospital, 1987. Residency, University of Kansas, 1989. Member, American Academy of Family Practitioners, American College of General Practitioners.

March, Allan W., Orthopaedics, Fayetteville. Born September 20, 1941, Chicago, IL. Pre-medical education, Dartmouth College, 1963. Medical education, Johns Hopkins University, Baltimore, MD, 1967. Internship, University of Pittsburgh, 1968. Residency, Johns Hopkins University, 1973. Military, US Navy, 1973-75. Appointments, Assistant Clinical Professor, UAMS. Practice experience, 17 years. Board certified. Member, American College Health Association.

RESIDENT SECTION

Langford, Timothy D., Urology, Little Rock. Born, October 1, 1960, Searcy. Pre-medical education, ASU, Jonesboro, 1984. Medical education, U of A, Little Rock, 1988. Internship/residency, UAMS.

Yates, Terrence R., Family Medicine, Little Rock. Born, January 1, 1962, Fayetteville. Pre-medical education, Harding University, Searcy, 1984. Medical education, UAMS, 1988. Internship/residency, UAMS.

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The Physician's Recognition Award is awarded to physicians who have completed acceptable programs of continuing medical education. The recipients for the month of February are:

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Wesley J. Ashabranner, Heber Springs
Eugene H. Ball, Rogers
Jos. K. Buchman, Little Rock
Kong Hua Lim Go, Dumas
Lindy Hodges, Little Rock
Terry Swaim, Rogers
Michael C. Young, Prescott
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In Memoriam

Eva F. Dodge, M.D.

Eva F. Dodge, M.D., of Tarboro, N.C., a retired physician, died Thursday, March 29, 1990. She was 93.

Dr. Dodge was a past professor of obstetrics/gynecology at the University of Arkansas for Medical Sciences, past assistant director of Planned Parenthood of America, and past president of the Pan-America Medical Women's Association. She was a member of the Arkansas Medical Society's 50 Year Club.

Dr. Dodge is survived by a sister, Cameron S. Weeks of Tarboro, N.C.

Edward J. Safranek, M.D.

Edward J. Safranek, of Fort Smith, died Friday, February 16, 1990. He was 58.

Dr. Safranek was a retired anesthesiologist. He was a member of the Arkansas Medical Society and the Sebastian County Medical Society. He was also a member of the International Anesthesia Research Society, the Arkansas Society of Anesthesiologists, the American Society of Anesthesiologists, and the Fort Smith Rose Society.

Dr. Safranek is survived by his wife, Mary Morris; four daughters, Rose Safranek of London, England, Barbara Safranek of New York, NY, Rita Kunau of Ann Arbor, MI, and Ann Safranek of Chicago, IL; six sons, James Safranek of Memphis, TN, Joseph and Daniel Safranek, both of San Francisco, CA, Robert Safranek of Fayetteville, Richard Safranek of Baltimore, MD, and Matthew Safranek, who lived at home; his brother, Louis Safranek of Omaha, NE.

Ellidee Dotson Thomas, M.D.

Ellidee Dotson Thomas, M.D., of Fayetteville, died, Friday, March 9, 1990. She was 63.

Dr. Thomas was a professor of pediatrics at the University of Arkansas for Medical Sciences and director of the Northwest Arkansas Neurodevelopment Center. She was a member of the American Medical Association, the Arkansas Medical Society, the Oklahoma County Medical Society, and the Oklahoma Medical Society. She was also American Acedemy of Neurology, the International Child Neurology Association, a Diplomate American Board of Pediatrics, and the American Medical Woman's Association. She was an Air Force Captain during the Korean War.

Dr. Thomas is survived by her husband, Gordon Thomas; one daughter, Ardel Marie Thomas, of Boulder, CO; her parents, Mr. and Mrs. Ewell dotson of Huntsville, AL; three brothers, Hugh Dotson of Tahlequah, OK, Kenneth Dotson of Huntsville, AL, and Kay Dotson of Seminole, OK.

TAKE THE FIRST STEP TO RECOVERY

The Physicians Health Committee exists for you, the physician who is struggling with drug and/or alcohol addiction. The committee is composed primarily of physicians who have "been there" and only want to help their colleagues from making the same mistakes.

The committee members are willing to set up interventions, recommend treatment, and help with aftercare and re-enty.

The committee is not involved in any legal, moral or punitive judgements.

ON CALL FOR YOU

Don't throw away your profession because of drugs and/or alcohol. Contact our Physicians Confidential Assistance Hotline at (501) 370-8221. Only specially trained personnel will return your call. Or contact the Arkansas Medical Society office at (501) 224-8967 or 1-800-542-1058 and ask for the name of one of the Physicians Health Committee members.

All inquiries are confidential within the committee and no names or locations are necessary when contacting the Society office.

Resolutions

Hal R. Black Jr., M.D.

Whereas, the membership of the Pulaski County Medical Society notes with sadness the death of one of its esteemed members, Hal R. Black Jr., M.D.; and

Whereas, he had been a faithful member of this Society for over thirty-five years; and

Whereas, he was held in highest regard by both his patients and his peers for his immeasurable contributions to the health of the community and to the advancement of his chosen field of Urology; be it therefore

RESOLVED, that this resolution be included in the archives of this Society; and

RESOLVED, that a copy of this resolution be mailed to Dr. Black's family as an expression of our heart-felt sympathy; and

RESOLVED, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted
Executive Committee
March 21, 1990

By Order of the Memorials Committee
Marlon J. Doucet, M.D., Chairman
Henry Hollenberg, M.D.
Robert Watson, M.D.

Memorials honoring Arkansas Medical Society members and their spouses can be made to the Medical Education Foundation for Arkansas (MEFFA), P.O. Box 5776, Little Rock, AR 72215. Call the Society at (501) 224-8967 or 1-800-542-1058 for more information.

John Schuler McKinney, M.D.

Whereas, the membership of he Union County Medical Society notes with profound sorrow the recent death of an esteemed colleague, John Schuler McKinney, M.D.; and

Whereas, he was a valued member of the Medical Society since 1950 and was known for his compassion and understanding to his patients and to his friends; and

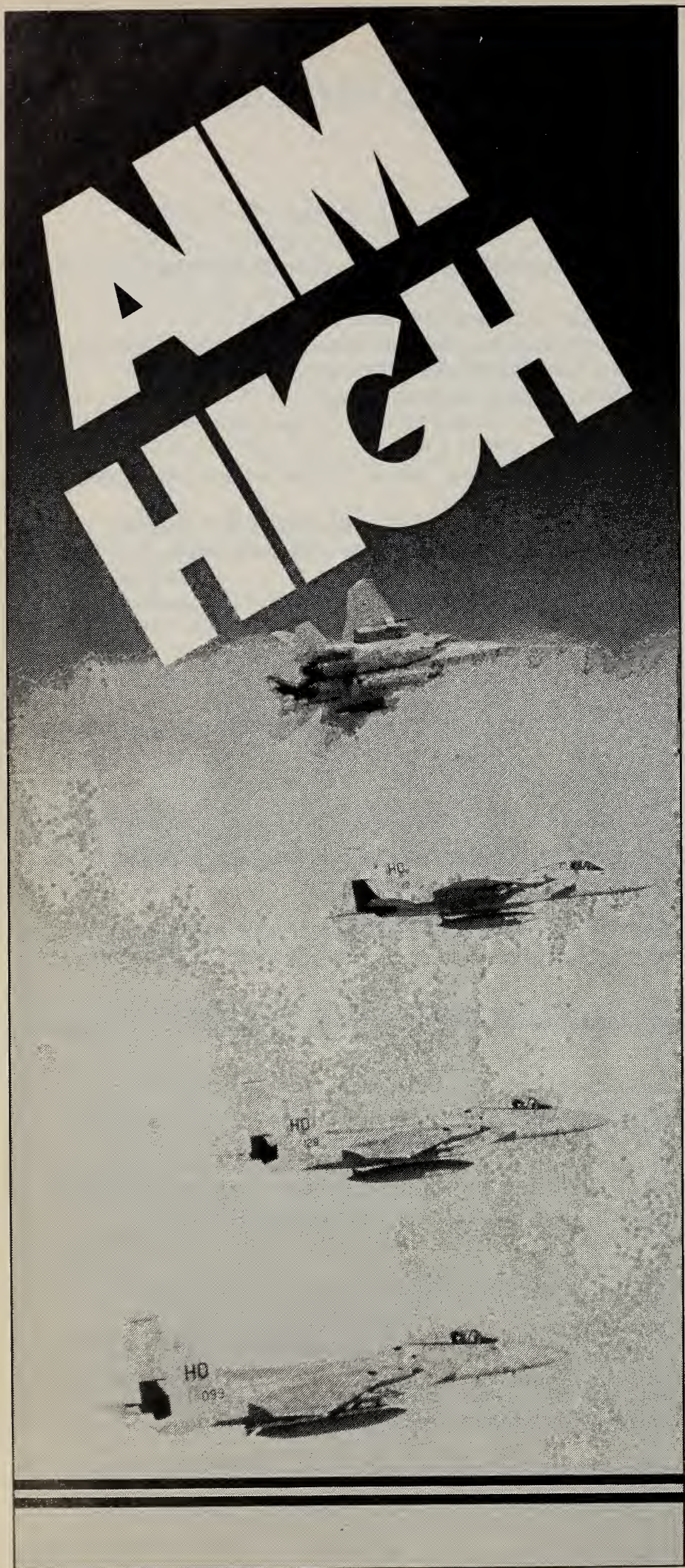
Whereas, Dr. McKinney devoted his life to the bettermanet of the health of his patients for the thrity-five years; be it therefore

RESOLVED, that we adopt this resolution and designate that it be a part of the permanent adrchives of the Society; and

RESOLVED, that a copy be forwarded to Dr. McKinney's family in order to express our profound loss; and

RESOLVED, that a copy be made to the *Journal of the Arkansas Medical Society* for publication.

Adopted: Union County Medical Society
March 13, 1990



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AIR FORCE

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Physician's Recognition Award

The Physician's Recognition Award is awarded to physicians who have completed acceptable programs of continuing medical education. The recipients for the month of March are:

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References

1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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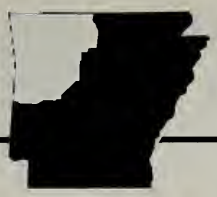
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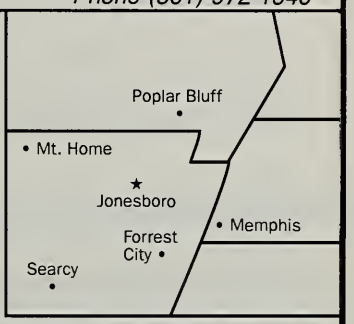
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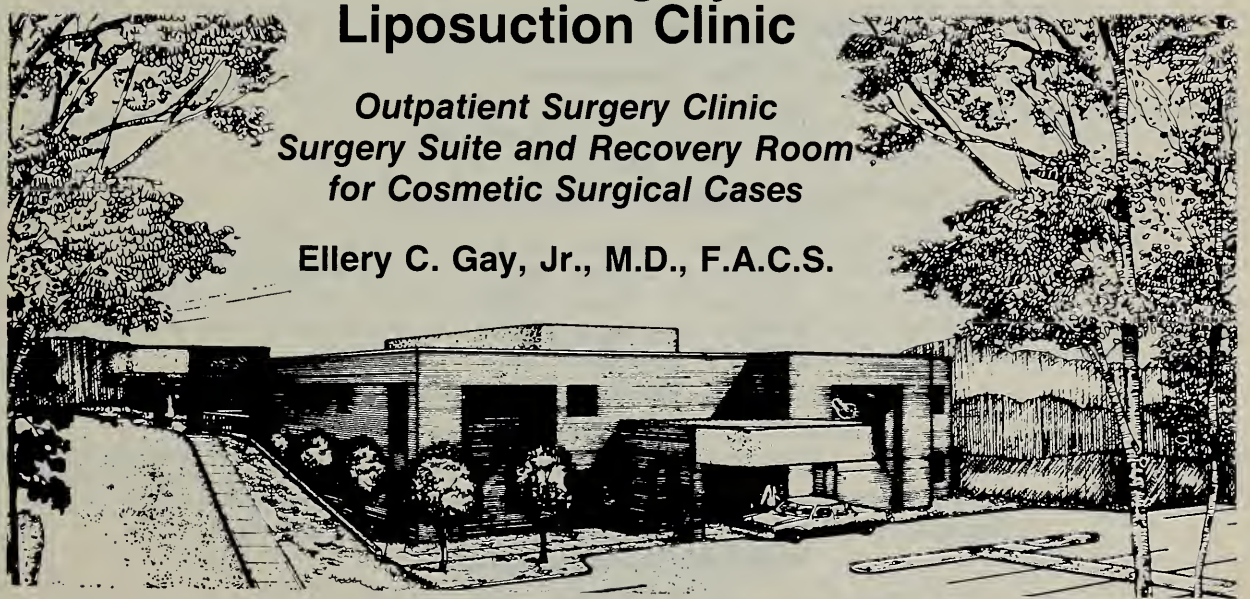
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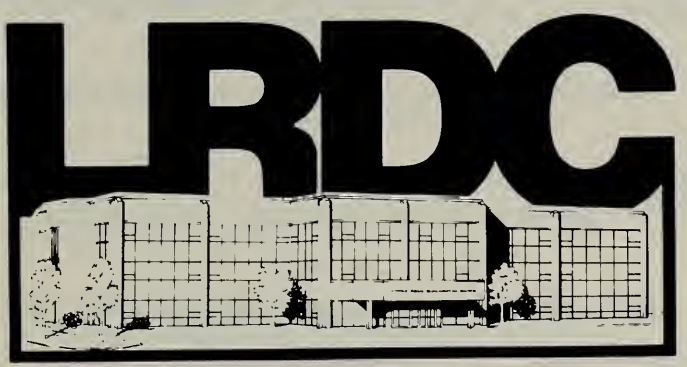
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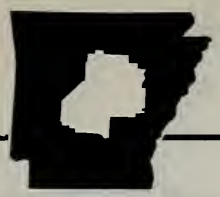
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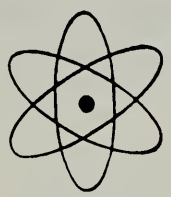
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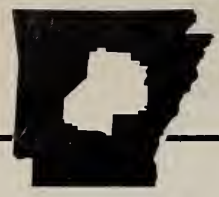
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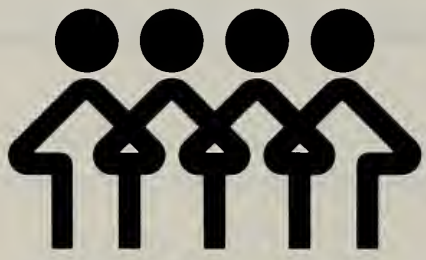
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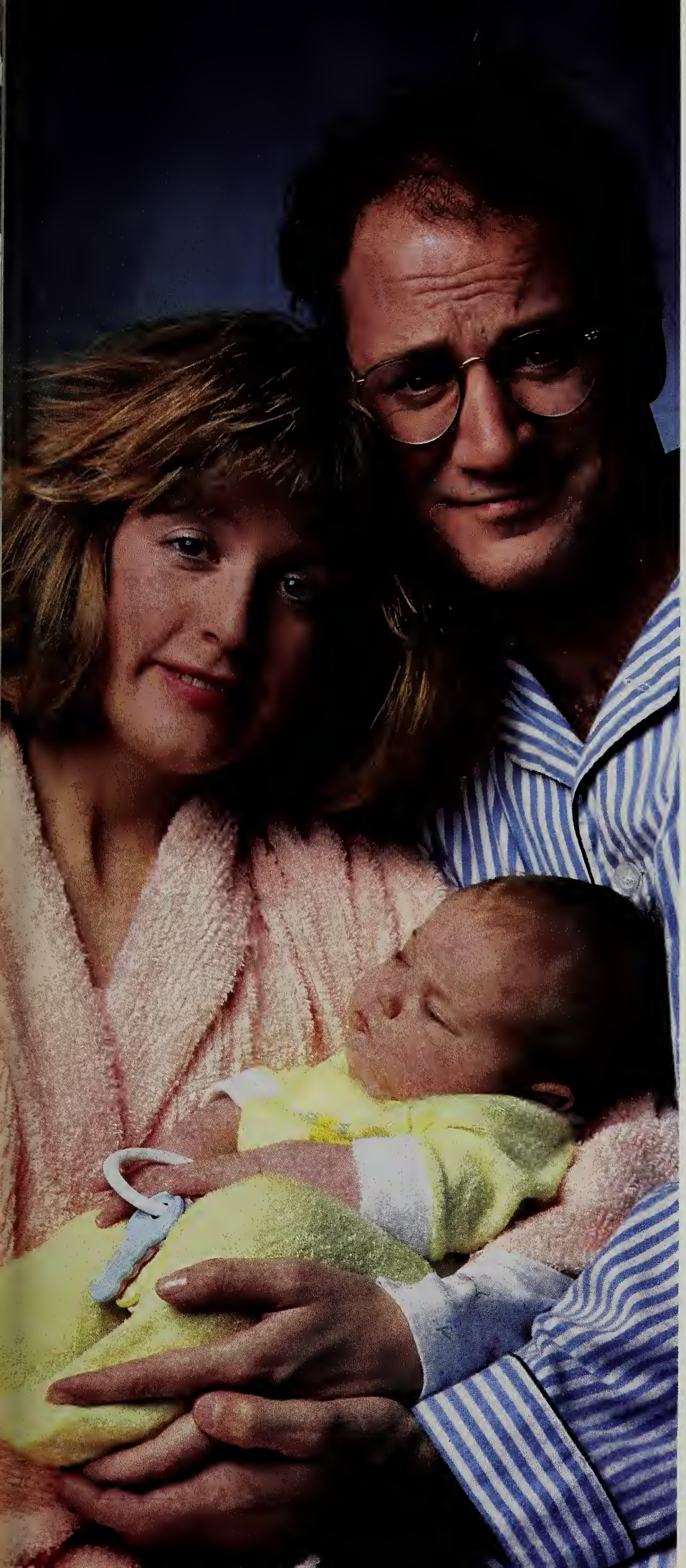
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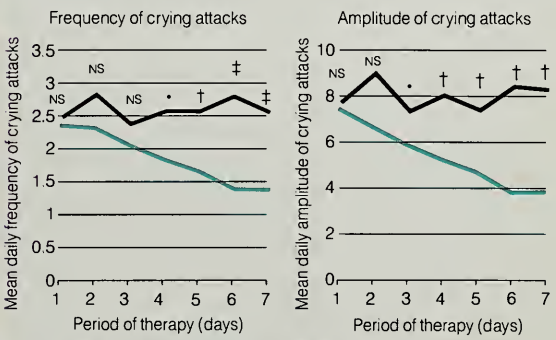
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